# NATIONAL REPORT - CANADA:

# TEN-YEAR REVIEW OF THE WORLD SUMMIT FOR CHILDREN

*Submitted to the*

Executive Director, UNICEF, in preparation for the United Nations General Assembly Special Session, September 19 to 21, 2001

Canada

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# FOREWORD

Canada is pleased to present its national report to the Executive Director of UNICEF, in preparation for the Special Session on Children of the UN General Assembly, to be held in New York, September 19-21, 2001. Canada, as an initiating country of the World Summit for Children, remains committed to the goals and ideals of the Summit, and looks forward to developing the future priority areas for children in the new millennium.

The report outlines the progress made by Canada in achieving the goals set at the World Summit for Children in 1990, and has been prepared according to the guidelines for the preparation of country reports, issued in 2000 by the Executive Director of UNICEF. As advised by the guidelines, the structure and content of Canada's report is intended to build on reports under international treaties such as the *Convention on the Rights of the Child*, major United Nations Action Plans and reporting exercises, and numerous domestic initiatives related to public accountability, government performance and outcome monitoring. Since the report concentrates on presenting a portrait of the progress made by Canada in achieving the goals of the World Summit for Children, it has drawn from, but does not intend to duplicate these other reporting exercises.

The report does not propose future initiatives for consideration at the Special Session on Children. Rather, Canada will continue to provide input through its active involvement in the work of the United Nations Preparatory Committee for the Special Session.

## 1. The Context for Canada's Children in the 1990s

In the ten years following the World Summit for Children, Canada has taken a range of actions to enhance the well-being of children. Through these measures and through the collective efforts of Canadians, Canada has made progress with respect to many of the goals set at the Summit. This progress includes a reduction in child and maternal mortality rates and certain childhood illnesses; increased immunization coverage; and enhanced access to information for children. As the decade closes, Canadians remain conscious that while successes for children have been significant, there remains work to be accomplished to ensure the rights, well-being and optimal development of children in Canada and abroad.

The Government of Canada's strategy at the outset of the 21st century focuses on children and youth, knowledge and education, health and the environment, within the context of preparing for the 'new economy'. This focus includes increased maternity and parental leave benefits; a federal-provincial agreement that provides greater support for early childhood development; more after-tax money in the hands of families; more family friendly workplaces; modernization of family law; significant investments in the National Child Benefit; strengthened learning opportunities through an expanded School Net; and special attention to the rights of the child in Canada's foreign policy and official development assistance. Certain elements of this plan are described in greater detail below.

During the 1990s, actions to enhance the well-being of children by the Government of Canada have included new legislation and legislative change; policy strategies and action plans; tax measures to benefit families; agreements with provincial and territorial governments; new and enhanced programs; and partnership initiatives with the voluntary and private sectors. This report provides a brief description of some of the key measures taken by the Government of Canada.

Furthermore, during the 1990s, the federal and provincial governments worked together to make investing in children a national priority This co-operation between governments on behalf of children is a central element in Canada's National Child Benefit (NCB) initiative, the ongoing development of the

National Children's Agenda (NCA), and in the recent initiative on Early Childhood Development*. These initiatives are described in detail in Section 3 of this report.

Unless otherwise mentioned, the report does not describe measures taken by provincial governments, although their impact is captured in the overall portrait provided of the progress made by Canadian children during the 1990s. It is also worth noting that communities and community groups play a significant role in the well-being of children in Canada.

The progress achieved for children in the 1990s took place in a context of high common resolve among Canadians to give special attention to the well-being and development of children and their families. Both in Canada's domestic legislation and the international agreements it supported, the concepts, values and language encompassed in the *Convention on the Rights of the Child* became increasingly common during the 1990s. For instance, the Convention has been influential to legislative developments in the areas of child prostitution, child sex tourism, criminal harassment and female genital mutilation, as well as in the ongoing renewal of youth justice. Also, recent international agreements supported and promoted by Canada – such as the *Optional Protocol to the Convention on the Rights of the Child on Involvement of Children in Armed Conflict; the Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution, and Child Pornography*; *the Hague Convention on the Protection of Children and Co-operation in Respect of Intercountry Adoption*; *the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction*; *ILO Convention No. 182 on the Elimination of the Worst Forms of Child Labour,* and the *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children*, supplementing the *United Nations Convention on Transnational Organized Crime* – are all examples of concrete international actions which have expanded and reinforced the commitments made under the *Convention on the Rights of the Child.*

* While sharing the same concerns on early childhood development, Québec does not adhere to the present federal-provincial-territorial document because sections of it infringe on Québec's constitutional jurisdiction on social matters. Québec intends to preserve its sole responsibility for developing, planning, managing and delivering early childhood development programs. Consequently, Québec expects to receive its share of any additional federal funding for early childhood development programs without new conditions.

In the early and mid-1990s, Canada's public finances were threatened by budget deficits and a high national debt. This situation represented a risk to social programs and to the quality of life of Canadians. As a result, the government acted to review public expenditures and to establish targets for the reduction of budget deficits. Having achieved its deficit reduction targets, the government is able to implement new investments of public expenditures in areas of concern for Canadians.

Canada's federal system of government, with constitutional powers shared between the federal, provincial and territorial governments, and the dual nature of its legal system, encompassing common law and civil law traditions, are two key elements which shape the way government decisions are made. In Canada, all levels of government and First Nations, along with parents, families, communities and the voluntary and private sectors, play key roles in ensuring the well-being of children. For a discussion of Canada's system of government, the judiciary and definitions of terms describing the Aboriginal Peoples of Canada, see Appendix 2.

The country's changing demographic profile also shapes the context for government action for children and families. In particular, with a higher birth rate than the Canadian average, Aboriginal Peoples within Canada represent approximately 3 per cent of the total Canadian population, a percentage that has almost doubled across the country over the last fifteen years. At the outset of the new century, Aboriginal children represent the fastest growing population in Canada.

### *The Legacy of The World Summit for Children in Canada*

Canada was one of six initiating countries that assisted UNICEF in the preparations leading to the 1990 World Summit for Children. Canada was also pleased to have the opportunity to act as co-chair of the Summit, which brought together the Heads of State or heads of government of 71 countries and ministerial representatives of 88 other countries. Following the Summit's endorsement of the Declaration and Plan of Action, the Government of Canada initiated a National Plan of Action: a 5-year, multi-sectoral initiative entitled *Brighter Futures*. The initiative was designed to address conditions that put children at risk. Brighter Futures represented a $500 million investment by the government over 5 years.

Canada also completed a mid-decade review in 1996, outlining the efforts made since the Summit to implement its goals. The review coincided with a larger assessment of the Brighter Futures Initiative, and provided the government with an opportunity to evaluate the impact and effectiveness of the range of initiatives in its Plan of Action.

Along with the many innovative programs that were established following the World Summit for Children, and which remain part of Canada's current commitment to its children, the most significant and lasting legacy of the Summit has been the ratification and implementation of the *Convention on the Rights of the Child*. Since ratification in 1991, Canada has submitted one periodic report under the Convention, with submission of its second report expected shortly. These two reports cover the actions taken by federal and provincial governments up to 1993, and from 1993 through 1997, respectively.

## 2. Process for the End of Decade Review

Canada's ten-year review of progress since the World Summit for Children has been a process that has engaged voluntary sector organizations involved in issues affecting children, and has encouraged the participation of children and youth. The federal government has also invited the participation of Canada's provincial and territorial governments in this process, through the Federal-Provincial-Territorial Committee of Human Rights Officials. More specifically, provinces and territories have reviewed Canada's National Report and, in some cases, have provided supplemental information that has been included in the body of the report or in an appendix (See Appendix 3).

To involve voluntary sector organizations and children and youth in this review, the federal government has worked in partnership with two Canadian organizations, the Canadian Coalition for the Rights of Children (CCRC) and Save the Children Canada (SCC). Through a process led by the CCRC, voluntary sector organizations will have the opportunity to be actively involved in preparations for the Special Session. They will identify and review priorities in preparation for the Special Session and will contribute to the process of formulating positions on issues to be addressed at the meeting. Second, through a variety of means, including focus groups held in eight sites across the country, participation through the Internet, and through the direct involvement of youth in preparatory meetings and in the September 2001 Special Session, the federal government and Save the Children Canada aim to ensure that Canadian children and youth have an opportunity to have their views heard during Canada's review process, and that following the Special Session, among other activities, they are able to share their stories with other youth in Canada.

Most data presented in this report originates from one of Canada's large population-based surveys, such as the General Social Survey; the National Population Health Survey; the Survey of Labour and Income Dynamics; as well as the National Longitudinal Survey on Children and Youth (NLSCY). Launched in the 1990s, with data first collected in 1994, the NLSCY has begun to provide a more complete picture of the issues facing children, youth and their families in Canada. More information on the NLSCY is given in Section 3 of this report. The present document builds on two Canadian reports under the *Convention on the Rights of the Child*, which provide a comprehensive review of actions taken for children during the 1990s.

## 3. Action at the National and International Levels

Many important initiatives for children have been launched in Canada since 1990, influenced in part by the attention placed on the rights, well-being and development of children following the World Summit. The Government of Canada, in partnership with the efforts of parents, communities, other governments, and the voluntary and private sectors, contributes to ensuring the optimal development of children. Since 1990, all governments have succeeded in achieving a number of important milestones for children. Below is a list of key actions taken by the Government of Canada. Other equally important initiatives are described in the theme areas in Section 4, while many important emerging actions are described throughout the report.

***National Action for Children***

There are many different approaches that can be taken to improve the well-being of children. For this reason, federal, provincial and territorial governments have acknowledged the need to develop an integrated approach to the many issues encountered by children and families. Governments in Canada have demonstrated over the last three years that they can work together to help families with children and can take actions ensuring that children can have the basic necessities to grow into healthy, educated and productive members of society.

Drawing from the wealth of research, evidence and experience generated by experts and non-governmental organizations, governments have begun developing the National Children's Agenda (NCA). The NCA is a co-operative effort by governments in Canada to ensure that all Canadian children have the best opportunity to develop their potential. As a first step in the development of the NCA, governments collaborated on a 'shared vision' for Canada's children. The shared vision includes goals for all Canadian children: to be healthy (physically and emotionally), safe and secure, successful at learning, socially engaged and responsible. The vision also identifies six areas in which collaboration by governments could enhance child well-being: enhancing early child development; supporting parents and strengthening families; improving income security for families; providing early and continuous learning experiences; promoting healthy adolescent development; and creating safe, supportive and violence-free communities. Governments sought feedback from Canadians on their vision in the Spring/Summer of 1999 and refined the vision to reflect comments received.

In 1996, the Prime Minister and provincial Premiers identified child poverty as a national priority, and work began by Social Services Ministers to develop an integrated child benefit. The result was the launch of the National Child Benefit (NCB) initiative between federal, provincial, and territorial governments and First Nations in July 1998. The goals of the NCB are to help prevent and reduce the depth of child poverty; promote attachment to the labour market by ensuring that families will always be better off as a result of working; and reduce overlap and duplication by harmonizing program objectives and benefits and simplifying administration. As its contribution to the NCB, the federal government has consistently increased benefits for low-income families with children. For their part, most provinces, territories and First Nations are adjusting social assistance payments for families with children, while ensuring these families receive at least the same level of overall income support from governments. Provinces, territories and First Nations are reinvesting social assistance savings in complementary benefits

and services for low-income families with children. In this way the NCB is providing a more secure and uniform level of basic income support, benefits and services for children in all low-income families across Canada, whether these families are working or receiving social assistance.

Canada will therefore make a third significant investment in the National Child Benefit for low-income families with children, bringing the total increase in child benefits for low-income families to $2.5 billion annually by 2004. Once fully implemented, total federal child benefits will reach about $9 billion annually, compared to about $5 billion in 1996. Maximum federal child benefits will rise to $2,500 for the first child and $2,300 for each additional child. Middle-income families will also receive increased support. In all, changes to federal child benefits will assist nine out of ten Canadian children.

Work is also underway to address a number of recent commitments made by the Government of Canada with respect to children and families. For example, as of December 31, 2000, maternity and parental benefits will double from the current six months to one full year, and the leave available to adoptive parents will triple, from 10 weeks to 35 weeks. Families with children will receive tax relief averaging 27 per cent by the time the 2000 budget measures and measures announced in the October 2000 Economic Statement are fully in place.

Furthermore, on September 11, 2000, First Ministers, with the exception of the Premier of Québec, issued the "*First Ministers' Meeting Communiqué on Early Childhood Development.*" The Communiqué makes improving early childhood development (ECD) a national priority and commits federal, provincial and territorial governments to work together to improve services and supports for children up to six years of age. This initiative represents concrete action on early childhood development, one of the key policy areas identified in the National Children's Agenda. In support of the agreement reached by First Ministers, the Government of Canada will transfer $2.2 billion to the provinces and territories, via the Canada Health and Social Transfer, over the next five years. This contribution, plus additional contributions from provinces and territories, will be invested in four priority areas to: promote healthy pregnancy, birth and infancy; improve parenting and family supports; strengthen early childhood development, learning and care; and strengthen community supports.

These investments will translate into better access to early childhood development services such as pre-natal classes and screening, pre-school programs and child care, and parent information and family supports. Each provincial or territorial government will be able to tailor its early childhood development services to better meet the needs of Canadian children. Regardless of the range of investments they choose, governments have agreed to report publicly on their investments and the results for children and families.

Supported by research that demonstrates the importance of health and social investments during the early years of life, the government has introduced and enhanced a number of initiatives to help Canadian children develop to their full potential. Federal programs such as the Community Action Program for Children (CAPC), the Aboriginal Head Start Program (AHS) and the Canadian Prenatal Nutrition Program (CPNP) recognize the importance of early childhood development, parental involvement and education, cross-sectoral approaches for children's well-being, and partnerships with

other governments, non-governmental agencies and communities. These community-based programs reach over 100,000 Canadian children and parents in over 1,000 communities each week.

In the ten years since the World Summit for Children, Canada has placed itself in a leadership position with respect to knowledge on early childhood development. Through such initiatives as the National Longitudinal Survey of Children and Youth (NLSCY), Understanding the Early Years (UEY), and Child Care Visions (CCV), the federal government has development mechanisms for monitoring early childhood development, helping policy makers decide which policies and programs best support children and their families.

The NLSCY is a research program that tracks the health and well-being of a large sample of Canadian children over the long term. It will provide the government with a better understanding of the factors that contribute to positive child development, and will be used by governments to develop and evaluate a wide range of policies and programs targeted at children and youth.

At the community level, UEY is a research initiative that focuses on children under the age of six and involves teachers, parents, guardians and community agencies. It helps communities understand how their children are doing and how best to respond to their needs. With this information, communities can put in place specific action plans that will help their children—both before and after they enter school—to reach their full potential. *Child Care Visions* is a national child care research and development contributions program. The goal of the program is improving the quality of child care by studying the adequacy, outcomes and cost-effectiveness of current child care practices and service delivery models.

All Canadian children must be able to share in the collective benefits of meeting the World Summit goals. Throughout the last decade, the Government of Canada worked to enhance the well-being of Aboriginal peoples, including Aboriginal children. The *Inherent Right Policy* (1995) recognizes the right of Aboriginal peoples to govern themselves in key areas of responsibility. In response to the Report of the Royal Commission on Aboriginal Peoples (RCAP), *Gathering Strength: Canada's Aboriginal Action Plan* (January 1998) seeks to renew partnerships, strengthen Aboriginal governance, develop a new fiscal relationship between Aboriginal governments and institutions, and support communities, people and economies. Measures announced as part of *Gathering Strength* include a Statement of Reconciliation by Canada, formally acknowledging and regretting historic injustices; community healing to address the effects of physical and sexual abuse in the residential schools system; an Aboriginal languages program; an on-reserve Aboriginal Head Start program; resources to increase the number of adequate housing units on reserve; and additional resources to address the inadequacies of water and sewer facilities on reserve.

A young person's right to access information from a wealth of sources is an important element of the *Convention on the Rights of the Child* and the goals of the World Summit for Children. Contributing to the fulfilment of this right, the federal government established Canada's *SchoolNet* in 1993, a collaborative effort to connect all Canadian public schools and public libraries to the Internet by March 31, 1999. This goal was achieved, making Canada the first nation in the world to connect all its schools and libraries. The project brings together provincial and territorial governments, universities and colleges, education associations, the information technology industry and other private sector representatives.

Canada's *SchoolNet* will enhance the access of Canadian children to information promoting their rights, well-being and development.

***International Action for Children***

Throughout the decade, the rights of children have been a priority within Canada's foreign policy and official development assistance. Canada has been a leader in promoting the rights of children throughout the world and in ensuring their survival, development and protection from exploitation and abuse. Canada has effected change by creating and sustaining constructive bilateral relationships with other countries and through cooperative efforts with international agencies such as UNICEF and by encouraging partnerships with both Canadian and developing country NGOs and other members of civil society. Key international initiatives supported by Canada include initiatives for war-affected children and for reducing poverty and debt among developing countries.

The Government of Canada will continue to maintain its commitment to the world's children. In April 2000, Canada and Ghana co-organized a Conference on War-Affected Children in West Africa, which produced a comprehensive Declaration and Plan of Action addressing the range of problems faced by war-affected children. Canada carried this approach to the International Conference on War-affected Children that took place in Winnipeg in September 2000. Following the Winnipeg Conference, the government is committed to timely, effective follow-up and implementation of the *Agenda for War-Affected Children*, agreed to at the Ministerial level meeting attended by over 40 ministers and representatives from 132 governments. Canada has also agreed to form a steering committee, including Ghana, the Secretary General's Special Representative for Children in Armed Conflict and UNICEF, to move the international momentum generated at the Winnipeg Conference forward to the United Nations Special Session on Children in 2001 and beyond. Canada, as one of the six initiating countries of the World Summit for Children, is actively participating in the preparations for the 2001 UN Special Session for Children and the subsequent new global agenda for children for the next 10 to 15 years.

The Canadian International Development Agency (CIDA) plays a key role in ensuring Canada meets its commitments to promote the rights and improve the lives of children in developing countries and countries in transition. Many development efforts benefit children by improving the well being of their families and communities. Canada also supports projects that directly benefit children. In 1996-97, CIDA supported 156 projects (with a direct or indirect impact on children) in the areas of child and maternal health, immunization, basic education, micronutrient deficiencies, institutional capacity-building in favour of the *Convention on the Rights of the Child*, and improved protection for children.

The goals of the World Summit for Children placed a special emphasis on the most basic human needs of children, including their health and nutrition. Since the 1980's, Canada has been a strong supporter of international immunization and efforts in universal immunization, in particular the eradication of polio and the elimination of measles. During the 1990s, Canada provided approximately $14 million per year in financial support for international immunization efforts. Moreover, CIDA continues to fight priority childhood diseases such as malaria, pneumonia and tuberculosis, through such cost-effective interventions as insecticide-treated bed nets for malaria and improved access to diagnosis and treatment. CIDA has also been the co-founder and lead donor to the Ottawa-based Micronutrient

Initiative, the lead bilateral donor to salt iodization programs, and a lead donor to fortify foods around the world with vitamin A, iron and other vitamins and minerals.

On September 5, 2000, Canada's Minister of International Cooperation unveiled *Social Development Priorities: A Framework for Action*. The Framework outlines how Canada will bolster and strengthen programming devoted to four priority areas of social development — health and nutrition, basic education, HIV/AIDS, and child protection — with gender equality as an integral part of all these priority areas. The Framework will also strengthen Canada's international aid programming by building on existing expertise in these priority areas and by implementing new and innovative approaches to development. Over the next 5 years $2.8 billion will be budgeted for these 4 priorities.

Children are a key beneficiary group of the health and nutrition, education and HIV/AIDS components of CIDA's Social Development Priorities. For example, the *Health and Nutrition Action Plan: Draft for Consultation*, will have a strong emphasis on child nutrition and health. Because of the known relationship between inadequate diet and disease, child survival, growth and development requires special attention to improvements in nutritional status. Canada will continue to work with international health initiatives such as the Global Alliance for Vaccines and Immunization (GAVI), Roll Back Malaria (RBM) and the Global Stop Tuberculosis Initiative (STB). Also, CIDA's *HIV/AIDS Action Plan* will put greater emphasis on children infected with and affected by HIV/AIDS, such as orphans. Programming will focus on providing shelter and schooling, supporting early childhood development projects, strengthening networks within the children's communities and promoting best practices, including child to child and participatory research approaches. The *Basic Education Action Plan: Draft for Consultation*, in addition to targeting efforts to eliminate gender disparities by 2005, will focus on strengthening the access and quality of universal primary education with a special emphasis on girl child education.

If all children are to benefit from the goals set at the 1990 World Summit, more attention must be paid to those children who need special protection and who may not be reached by mainstream development programs. The *Child Protection Action Plan* focuses on child labourers, war-affected children, children in conflict with the law or in the care of the state, disabled children, street children and children from ethnic minorities. Over the next five years CIDA will invest $122 million on programming for these children. Initially, over the next two years, CIDA will concentrate on child labour and war-affected children. As part of the Agency's commitment to developing new approaches to development assistance programming, a $2 million fund for research on child protection has been established over the next five years to support innovative research in this often overlooked area.

High debt burdens represent a critical obstacle to poverty reduction in many developing countries, especially of Sub-Saharan Africa. Debt payments displace spending on health, education and other social sectors.

Canada has been at the forefront in urging a swift and decisive approach to debt relief for the world's poorest countries both multilaterally and bilaterally. Canada recently challenged donors at the annual meetings of the IMF and World Bank to place an immediate moratorium on debt service payments from Heavily Indebted Poor Countries (HIPC). In December 2000, the Government of Canada announced its own moratorium on debt repayments from eleven heavily indebted poor countries, with debts to Canada

amounting to $700 million. The debt from these countries will be officially written off as they complete the HIPC process. In addition, Canada has contributed C$215 million to the debt relief trust funds at the IMF and World Bank to ensure timely debt relief. Canada is helping the poorest countries by committing to forgive 100 percent of the commercial bilateral debt owed by all nations qualifying for debt relief and making real efforts to reduce poverty and to improve governance.

Canada has always encouraged increased involvement by developing countries in a rules-based multilateral trading system, and recognizes that developing countries need assistance in building their trade-related capacity. Canada champions the view that social justice and environmental policy issues need to be addressed in tandem with trade liberalizing initiatives and other economic growth strategies if long-term poverty alleviation is to be sustainable. This approach applies to Canada's participation in the WTO, the FTAA, and other regional and bilateral trade fora. It will treat these issues as priorities in future trade negotiations. Free and fair trade make an important contribution to the growth and sustainability of developing economies, and to poverty alleviation throughout the developing world. Active Canadian participation in the World Trade Organization (WTO) underscores the Government of Canada's determination to see agreement on common rules to govern business transactions around the world. To reap the benefits of trading internationally, all players must know and agree to operate by the same rules in global markets. They must balance trade goals with a commitment to social justice and a sustainable world ecology.

# 4. Progress in Child Survival, Protection and Development

This section begins with a brief demographic portrait of Canadian children, followed by a profile of Canadian progress on each of the Summit's goals. A summary of this progress is presented in statistical format, in Appendix 1.

***Demographic Profile of Canadian Children***

Canadian children are a diverse group that makes up slightly more than one-quarter of the total Canadian population. They come from varied ethnic, religious, linguistic, and cultural backgrounds; they grow up in families with disparate levels of social and economic resources; and they live predominantly in urban centres. The *Convention on the Rights of the Child* defines a child as a person who is below the age of 18 years. For statistical purposes, this report considers children and youth as those who are 18 years and under, unless otherwise specified.

In the last decade of the millennium, Canada's demographic profile has undergone change. Between 1997 and 1999, there was a slight decline in the total number of children aged 0 (newborn) to 19 years in Canada: from 8,016,468 in 1997 to 7,979,251 in 1999. Children in this age group currently represent 26.2% of the total Canadian population. Almost 2 million of these children are under the age of 5; more than 4 million are between the ages of 5 and 14; and slightly more than 2 million are between the age of 15 and 19. The proportion of children aged 0 to 14 years in terms of total population varies by province/territory, ranging from a low of 18% in Newfoundland to a high of 38% in Nunavut, with the majority of Canadian children (78%) living in urban settings. The proportion of children as a percentage of the total Canadian population has declined since 1961 and is projected to continue to decline in the future: 25% in 2001, 24% in 2006, 22% in 2011, and 21% by the year 2016.

Canada's natural growth rate declined substantially between 1990 and 1995, from 7.7 to 5.7 per 1,000 population. The natural growth rate accounted for 47% of the population's growth in 1996, while immigration accounted for the remaining 53%. Nearly 5% of the children under age 15 were born outside Canada, and two-thirds of immigrant children live in the major urban centres of Montreal, Toronto, and Vancouver.

In addition, the structure of the Canadian family has also changed over the past decade. The proportion of lone parent families has increased from 20% in 1991 to 22% by 1996. The majority of lone parent families (83%) were headed by a woman. The average size of families in Canada has remained relatively stable in the 1990s; in 1997, the average family size in two-parent families was 3.1 persons and 2.5 persons in lone-parent families. Of the 5.5 million Canadian children up to age 13 in 1996, 84% lived with two parents and 16% lived with one parent.

In 1996, there were 280,415 Aboriginal children under the age of 15 living in Canada, representing 35% of all Aboriginal people identified in the census that year. When the Aboriginal children and youth populations (0 to 24 years) are combined, they represent 53% of all Aboriginal people. These 424,000 Aboriginal young people constitute 5% of all Canadian children under age 15 and 4% of youth aged 15-24.

The status Indian population is expected to increase at a rate of 2.1% per year over the next five-year period beginning in 1996. This growth rate compares to the general Canadian growth rate of 1.2% over the same period.

### *Status of the Convention on the Rights of the Child*

Canada ratified the *Convention on the Rights of the Child* in December 1991. Since that time, significant progress has been made in ensuring its broad and continued implementation in Canada.

For its part, the Government of Canada has shown a commitment to using the Convention as a guide for improving the lives of children. First, the federal government reviews all new federal legislation for its compliance with Canada's international human rights commitments, including its obligations under the *Convention on the Rights of the Child.* Also, the government has worked in partnership with an umbrella organization of Canadian voluntary associations, the Canadian Coalition for the Rights of Children, to systematically assess Canadian compliance in implementing the Convention. This exercise of monitoring the Convention's implementation goes beyond law to include the effectiveness of policies and programs for children. This non-governmental report will contribute to improved decision-making and outcomes in all sectors. In addition, the government has employed the Concluding Observations issued by the Committee on the Rights of the Child as a tool to assess which new initiatives have had a direct or indirect effect on children, and also an opportunity to emphasize certain subjects raised by the Committee in subsequent reports. Finally, with the Government of Alberta providing its official support for the *Convention on the Rights of the Child* in 1999, the Convention now enjoys the support of all jurisdictions within Canada.

Since its ratification, attention given to the Convention as a practical tool to ensure the rights of children has been both substantial and diverse. Non-governmental organizations (NGOs), municipalities, youth organizations, researchers, judges, advocates, governments, schools, police and professional associations have made the Convention relevant to their settings by developing training workshops, concrete plans for the participation of youth, school curricula for the primary and post-secondary levels, monitoring mechanisms to judge government performance and child and youth-friendly versions of the Convention to more easily share its content with young Canadians. They have built strong networks and lasting partnerships through the Convention.

In 1993, the Parliament of Canada adopted November 20 as *National Child Day*, as testament to the importance of children for both the present and the future of the country. The selection of the date was inspired by the adoption of the *Convention on the Rights of the Child* by the United Nations General Assembly on November 20, 1989. Since 1994, the Government of Canada has developed and disseminated educational and promotional materials to encourage schools, community groups, families and others who work with children across the country to mark this day. A *National Child Day Activity Guide* was created to assist youth, community groups, child care workers, schools, parents and others who work with children organize and promote National Child Day events. From 1994 to 1999, circulation of the Guide doubled, from 12, 000 to 24,000 copies. In addition to the conventional distribution of the Guide, there were 8,200 individual users who accessed the National Child Day website between 1999 and

2000. During the month of November 1999, there were 2,600 individual users who accessed the website, up from 1,800 in November of 1998.

In 1999, UNICEF Canada, in conjunction with Elections Canada, administered a national election on the rights of youth based on the *Convention on the Rights of the Child*. The election aimed to promote an understanding of Canada's electoral process among youth and to heighten understanding of and commitment to children's rights among both adults and children in Canada. *It's Your Voice: National Election for the Rights of Youth* took place nation-wide where young people in over 1100 primary and secondary schools voted for the right they felt was the most important to them. Students in all provinces and territories cast a total of 187, 757 votes. Results of the vote showed that students perceived family (24% of the total votes), food and shelter (20% of the total votes) and health (11% of the total votes) as the three most important rights.

### *4.2 Health and Sanitation*

From 1990 to 2000, progress was made in the health of Canadian children, and for the majority of these children, their health status remained excellent. Important challenges remain, however, in addressing the most persistent conditions of risk, and acting in other crucial areas to ensure optimal health for all populations of Canadian children. Particular challenges remain in relation to certain vulnerable populations and to Aboriginal children, the child population most at risk of poor health and social outcomes.

The factors that contribute to the health of children are wide-ranging. They can be as diverse as family income, social supports, education, access to health services, physical and social environments, biology and genetic endowment, gender and culture. The series of health indicators presented in this report offer a certain portrait of Canada's children, defined by the goals set at the World Summit for Children. A range of research and reporting initiatives, from the *National Longitudinal Survey of Children and Youth* to the *Report on the Health of Canadians*, contribute to a more comprehensive and constantly evolving portrait of the health status of Canadian children.

Two broadly recognized indicators of child health, and of a nation's health more generally, are the infant and child mortality rates. Canada has shown progress in both areas since 1990. First, the child mortality rate, the number of deaths among children from birth up to 5 years per 1000 live births, has fallen by one-third between 1990 and 1998, from a rate of 9 to a rate of 6. Similarly, the infant mortality rate, the number of deaths among children under 1 year per 1000 births, has also declined from 6.8 per 1000 live births in 1990 to 6 in 1998, following a low of 5.5 in 1997. These results are similar to those obtained by other industrialized countries. The current trend in Canada in both these areas appears to be a significant and steady reduction in infant and child deaths. With the ongoing efforts of governments, voluntary organizations and all Canadians, Canada is likely to see further progress in infant and child mortality levels. Among First Nations populations in Canada, there have also been significant improvements in infant mortality rates over the last two decades: the rate has fallen from 28 per 1,000 live births in 1979 to 11.98 in 1994. While progress has been made, however, the current rate remains approximately double that of the Canadian population as a whole.

Another important public health measure, low birth weight, has increased slightly over the ten-year period, but remains well below the World Summit goal of 10%. Between 1990 and 1996, the percentage of live births that were registered as less than 2.5kg increased from 5.4% (6.0% for males and 5.1% for females) to 5.8%. Through a range of programs, the Government of Canada remains committed to supporting pregnant women most likely to experience unhealthy birth outcomes, including low birth weight. When assessing perinatal health, it is equally important to consider the components of low birth weight: fetal growth and pre-term birth. The increased incidence of pre-term birth in Canada and other industrialized countries is among the most important perinatal health challenges facing industrialized countries.

Many of the most basic human needs remain at the foundation of children's healthy development, in both developing and developed countries. This is the case for the accessibility of safe drinking water and the sanitary disposal of sewage. In Canada, 99% of the population has access to safe drinking water. However, this high level of access does not mean that Canadians are complacent about the safety of drinking water. As a recent outbreak of E-coli in Walkerton, Ontario illustrates, Governments and all Canadians must remain vigilant to maintain the accessibility and quality of drinking water for today and the future.

Collaborative efforts between governments at all levels help to address the local environmental needs of communities. The Government of Canada has recently concluded agreements under the Infrastructure Canada program with every province and in partnership with municipal governments. The priority of the program is to invest in 'green' municipal infrastructure projects that include projects related to water and wastewater systems, water management, solid waste management and recycling, and capital expenditures to retrofit or improve the energy efficiency of buildings and facilities.

Safety of drinking water and sanitary disposal of sewage has most particularly been a concern among First Nations communities. While progress remains to be made, access to safe water and sanitation for First Nations has improved over the past 10 to 15 years. The government continues to work with First Nations and Aboriginal communities to enhance access to safe water and sanitation on-reserve.

Immunization has proven to be an effective and accessible means for the prevention of numerous potentially fatal diseases. In Canada, rates of immunization coverage have remained high throughout the 1990s. First, the proportion of two-year-old children immunized against diphtheria, pertussis and tetanus (DPT) has risen slightly from 82.3% in 1994, to 83% in 1998. Second, immunization coverage against polio among two-year olds has fluctuated but remains high, from 90% in 1996, to 86% in 1997 and returning to 90% in 1998. Third, coverage for measles at two years of age reached 93.6% in 1998, up from 91.4% in 1995. Effective immunization efforts show results in healthier outcomes for children. From 1994 to 1998, the annual number of measles cases among children under five years fell by 97.7%, from 523 cases in 1994 to 12 cases in 1998. Mass catch-up campaigns and the implementation of routine two-dose measles immunization programs across Canada in 1996 account for this decreased incidence.

Health outcomes among children linked to environmental factors have recently been identified as a growing concern for many developed countries, including Canada (See section 4.9–Environmental Protection). One of the clearest examples of this has been in the incidence of asthma among Canadians under 20 years of age. Among this group, 8% had asthma in 1990 compared to 12.2% in 1996-97. While

the precise factors causing this increase are still being explored, the government is committed to taking action on this issue, and to working in partnership with other governments, health professionals, research and voluntary organizations in order to reach effective solutions.

Substance abuse remains an important health issue affecting Canadian children and youth. Although the regular use of alcohol among youth is on the decline, tobacco and drug use remains high or has increased. Female rates of tobacco and drug use have dramatically increased and surpassed those of the males in the same cohort. Weekly consumption of alcohol among grade 10 students declined significantly over the decade, with the percentage of male students in grade 10 consuming alcohol at least once a week declining from a high of 30% in 1990 to 18% in 1998. A similar decline in female consumption patterns occurred over the same period, declining from 19% in 1990 to 10% in 1998. However, in 1998, 93% of males and 92% of females in grade 10 had tried alcohol. In comparison, tobacco use among Canadian youth has remained relatively high over the past decade, especially among females. This trend is opposite to the declining percentage of the adult population who smoke. Between 1994 and 1998, the percentage of female students in grade 10 who smoke daily has remained constant at 21%, and fallen from 16% to 15% for males. However, the percentage of students in grade 10 who had tried smoking increased from 58% to 61% (males) and from 64% to 66% (females) between 1994 and 1998.

During the 1990s, there has been a shift in the overall portrait of HIV/AIDS in Canada. In 1999, there was an estimated 49,800 people in Canada living with HIV infection, including those living with AIDS, compared with an estimated 40,100 at the end of 1996. However, during the 1990s, there has been an overall decrease in the total number of AIDS cases in Canada. This decrease is similar to the situations in other developed countries.

Since 1980, there have been a total of 197 AIDS cases among children 0 - 14 years, of which 153 were attributed to perinatal transmission. HIV prevalence studies among pregnant women indicate a provincial rate for Canada of about 1-4/10,000. The number of new cases reported each year is declining with 12 new cases reported in 1996, down from its peak of 27 in 1995. Among Canadian youth aged 10 to 24 years, 600 AIDS cases were diagnosed, representing 3.5% of the total 16, 913 cases reported by December 1999. Of the 45,534 positive HIV tests reported by the end of 1999, 597 or 1.5% were youth's ages 15 to 19 years. HIV prevalence and incidence data show highest risk among street youth and youth who inject elicit drugs.

At the end of 1999, an estimated 6,800 women were living with HIV infection, an increase of 48% from the 1996 prevalence estimate of 4,600. In 1999, women accounted for 14% of the prevalent HIV infections compared to 11% in 1996. The number of newly infected women remained just below 1,000 cases per year in both 1996 and 1999 (950 and 917 respectively). In 1999, 54% of all new HIV infections among women were attributed to intravenous infection and 46% were attributed to the heterosexual exposure category.

Action at the national level has been undertaken through a National HIV/AIDS Network for Children, Youth and Families. The Network creates supportive environments for children, youth and families through information sharing, support groups, research and mentorship to organizations that serve

them. The Network adheres to the principles of participation, quality of life and development, protection and non-discrimination for children, youth and families living with HIV/AIDS.

### *4.3 Food Security and Nutrition*

While a comprehensive portrait of the food security and nutritional status of Canadian children and families is not complete, a number of findings offer valuable insight. First, the National Longitudinal Study on Children and Youth indicates that in 1994, 1.2% or 57, 000 Canadian families reported having experienced hunger because of a lack of food or money. Also, Canada has seen an increase in the use of food banks during the 1990s: approximately 726,000 Canadians used a food bank in March 2000, twice the amount as for the same month in 1989. Children living in families who used food banks represented approximately 40% of total users. None of these figures alone, however, present a complete profile of those Canadians whose food security may be at risk. Ongoing work is required in Canada to properly assess children's nutritional status and family food security.

The Summit's goals related to strengthening child and family food security and enhancing the nutritional status of children have provided the government with an opportunity to assess the effectiveness of initiatives in this area for children. Through priorities established by federal, provincial and territorial governments, and multi-sectoral strategies such as *Canada's Action Plan for Food Security* and *Nutrition for Health: An Agenda for Action,* action is being taken to address the diverse set of factors contributing to the food security and nutrition of children and families, including food safety, agriculture, nutritional education, trade and family income support (for further information on income support, see especially Sections 3 and 4.5).

In the area of child obesity, reliable information regarding young children (from ages 0 to 5 years) does not exist in Canada. For school-aged children, available data has not been updated during the 1990s. Existing data, however, indicates that the proportion of children in grades 4 and 9 (approximately 9 years old and 14 years old, respectively) who are overweight or obese increased in Canada over the 10 years from 1981 to 1991. In 1981, 14% of girls and 18% of boys were obese. In 1991, in comparison, 24% of girls and 26% of boys were overweight or obese. A similar phenomenon has been observed in other industrialized countries. More research is required in Canada to better understand the factors that contribute to healthy nutritional outcomes for Canadian children.

The promotion of breastfeeding has long been seen as a first step in ensuring a healthy childhood. While there is a considerable range of data on initiation and duration of breastfeeding in Canada, rates come from a variety of sources and are often based on varied definitions of breastfeeding, from initiation to maintenance over a given period, usually from 2 to 6 months. For instance, in 1990, 43% of women 15 years old and over reported having breastfed their child. In comparison, in 1994, the proportion of children under 2 who were ever breastfed was 69%. In addition, it is also known that the proportion of new mothers breastfeeding their babies at the time they left the hospital has increased from 73% in 1994 to 79% in 1996-97. Despite statistical variations, then, data suggests that Canada has recorded progress in the proportion of women who are choosing to breastfeed their children. In July 1999, the Hôpital Brome-Missisquoi-Perkins Hospital in Quebec was designated Canada's first Baby Friendly Hospital according to

the WHO-UNICEF international program. The Baby Friendly Hospital Initiative (BFHI) aims to protect, promote and support breastfeeding and thereby the health and well-being of mothers and their babies.

### *4.4 Status of Girls and Women*

Gender equality is a fundamental element of Canada's domestic and foreign policies. It is based on the principle that women's rights are an essential and inherent component of progress on overall human rights and democratic development; and that sustainable and equitable development will only be achieved if women are able to participate as equal partners and decision-makers in the sustainable development of their societies.

Canada participated in the United Nations General Assembly Special Session, "Women 2000: Gender Equality, Development and Peace for the 21st Century." This meeting adopted by consensus a Political Declaration and Outcomes document on "Further Actions and Initiatives to implement the 1995 Beijing Declaration and Platform for Action" (PFA). Canadian objectives for the Special Session included: advancing the human rights of women and girls throughout their lives; ensuring the diversity of women's experiences are respected and valued; and building partnerships with civil society, other governments and international organizations.

Traditionally, girls and women in Canada have been the family members primarily responsible for maintaining the home and caring for children and ill or elderly family members. Women's role in the family, as guardians of the health of family members and as primary caregivers in most instances, is not always well recognized. While there have been recent improvements in employment prospects and income equality for women, they remain primarily responsible for daily unpaid, household work and increasingly for paid work.

Important progress has been made in achieving better access to education for Canadian women. Overall, women's level of education has risen. In 1997-98, women represented 55% of all full-time university students, 51% of all Master's degree students, and 43% of all doctoral students. Young women continue to be under-represented in math and physical science courses and in engineering and applied sciences (29% and 22% respectively).

During the 1990s, Canada has made progress in reducing maternal mortality – the number of deaths among women from pregnancy-related causes – often an indicator of high quality, safe and accessible health care services and facilities for women. Canada has a maternal mortality rate that is among the lowest in the world, falling from 6 per 100,000 live births in 1990 to 4 in 1995.

The proportion of women aged 15-49 who are using or whose partner is using a contraceptive method has remained stable over the past two decades. From 1980 to 1994, as well as from 1990 to 1999, the rate was approximately 73%. Women's familiarity with some of the most common forms of contraceptives -- oral contraceptives and condoms -- is also very high in Canada. In 1998, 94% of Canadian women aged 15 to 44 reported being familiar with oral contraceptives, while 91% reported being familiar with condoms.

In addition, the total fertility rate – the average number of live births per woman having reached the end of her child bearing period – has also remained generally stable. From 1990 to 1997, the rate decreased slightly from 1.7 births per woman to 1.6. Population trends among Aboriginal populations in Canada have followed a similar pattern to other social and demographic trends. While Aboriginal Canadians have made significant progress, social outcomes remain behind the Canadian population as a whole. The Status Indian population recorded a slight decrease in the total fertility rate for 1996. However, population projections from 1997 to 2005 suggest that the Aboriginal population will grow by 1.7% yearly, a rate higher than the Canadian rate of 1.1%. On reserves, the population is projected to grow by 2.3% over the same period.

Finally, during the past decade, there has been an increase in the median age of Canadian women at the time of their first pregnancy. The largest proportion of women in Canada have their first baby between the ages of 25 and 29. For instance, in 1993, 34.9% of women were aged between 25 and 29 years during their first pregnancy, while 28.9% were aged between 30 and 34 years. In 1996, the percentage of women aged 30 to 34 years had increased to 30.3%.

### *4.5 Parenting and Family Well-being*

Family life is a critical element in the healthy development and well-being of children. In the decade since the World Summit for Children, some important improvements can be observed: family income is on the rise; and parent-child interaction remains a priority for the majority of parents. While there have been improvements for Canadian families, further action is needed to address the problems that adversely affect family life and child well-being.

Parent-child interaction in the home continues to be of importance to Canadian parents, according to data from the National Longitudinal Survey of Children and Youth (NLSCY). Between 1994 and 1996, the number of parents who felt that good school grades are very important increased. By another measure, a correspondingly high percentage of parents check or help with their child's homework. Moreover, Canadian parents are increasingly using alternative means of disciplining their children. Data from the NLSCY indicates that the number of children whose parents never use physical punishment increased significantly between 1994 and 1996 in all age categories up to age 13. For example, in 1996, 64% of children aged 2 to 11 lived with parents who never used physical punishment, having increased from 56% in 1994.

The economic status of the average Canadian family has improved over the past decade. Family income rose significantly between 1997 and 1998: average after-tax family income was $49,626 in 1998, up 3.7% from 1997, higher than the pre-recession peak of $48,807 in 1989. The increase is also the strongest annual increase since 1989. The after-tax income in 1998 for two parent families with children under 18 was $55,074, up 4.7% from the year earlier; while lone-parent families averaged $26,279 after transfers and taxes, a 7.2% increase over the same period. Studies have also shown, however, that the average Canadian family requires 75.4 weeks on the job at an average wage to cover basic annual expenses. As a result, Canadian families require significantly more than one full-time income in order to meet their average annual expenditures.

Research shows that an increasing number of Canadian parents are entering the labour force. In 1998, 72% of children in two-parent families had both their parents working outside the home. In comparison, 68% of children in lone-parent families had both their parents working outside the home, up 7% from 1995. Also, Canadian parents are spending more of their time on paid and unpaid work, including a range of activities associated with employment and household tasks. In 1998, married men and women (aged 25-44) with children who were employed full-time spent approximately 43% of their time on paid and unpaid work, while lone-parent mothers (aged 25-44) spent 45% of their time on the same duties. Between 1991 and 1998, there was a 6% increase in the number of workers with dependants who reported excess tension due to work/family conflicts.

Over the course of the 1990s, progress in reducing poverty among families with children in Canada has been mixed, with some recent improvements being coupled with increases over the decade as a whole. First, with increased co-operation on measures addressing low-income among families and children, the collective actions of federal, provincial and territorial governments are bearing fruit. In recent years, there has been a reduction in the number of children living in low-income families. In 1998, 14.1% of Canadian children lived below Statistics Canada's low-income cut-offs **, a reduction from the 1997 level of 16.3%. However, levels of children living in low-income have not dropped as significantly as in previous economic recoveries. In addition, among certain population groups, poverty has proven to be more widespread. Aboriginal children, for example, experience a significantly higher incidence of poverty than the general Canadian population.

Reducing domestic poverty is an ongoing priority of the Government of Canada. As a result of funding increases between 1996 and 2001, maximum annual benefits under the National Child Benefit for a family with two children will increase by 79 percent from $2,540 to $4,544. Provincial-territorial and First Nations reinvestment and additional investment will reach $600 million in 2000-01 with these funds directed to a range of programs including child benefits, extended health care coverage, child care and children-at-risk services.

While most Canadian families faced increased economic and time pressures, the majority of families continued to cope well, and by some measures, seem to have improved. In 1996, 93% of Canadian children up to age 13 lived in families that functioned well, defined by a family's ability to cope with everyday problems, to communicate, and to interact with each other. By this definition, only 7% of families were considered to be having difficulty functioning, a slight improvement over 1994.

A growing body of scientific research suggests that success in a child's early years is a key to long-term healthy development. Building on this knowledge, and to assist parents in balancing work and family responsibilities, the Government of Canada has made a commitment to give parents the

** It should be noted that Canada has no official poverty measure. The most widely used proxy of poverty is Statistics Canada's low-income cut-offs (LICO), a relative measurement, which establishes a dollar figure below which a family is considered to be living on a low income. The LICO presented here is calculated using after-tax income.

opportunity to take more leave from work to spend more time caring for their new-born or newly adopted children in the critical first year of their life. Parental leave under the Employment Insurance (EI) program will be extended and benefits made more flexible and more accessible effective January 1, 2001. The EI program currently provides up to six months of maternity and parental leave benefits. The replacement rates for those benefits range from 55 per cent of insurable earnings up to a maximum of 80 per cent for low-income families eligible for the Family Income Supplement. The federal government has proposed that the maximum amount of child-related leave be doubled to one year. Benefits will be made more accessible by reducing the entrance requirements from 700 hours of insurable hours of work to 600. Parents receiving benefits will also be allowed to work approximately one day per week without seeing their benefits reduced. The extended benefits will be available to parents with a child born or adopted on or after December 31, 2000.

### *4.6 Early Childhood Development, Education and Literacy*

As is the case with health care, access to early childhood initiatives, education and literacy create and expand opportunities for children to develop to their full potential and to become active, participating members in the society in which they live.

#### *Early Childhood Development*

For Canadian families, new federal, provincial and territorial investments made possible by the Early Childhood Development Initiative (See Section 3) will ultimately mean better access to services such as pre-natal classes and screening, pre-school programs and child care, and parent information and family support. This will complement the current availability and variety of early childhood care and educational programs such as nursery schools, playgroups, day-care centres and mom and tot programs that Canadian children already enjoy. In 1994-95, there were 192,000 (39%) children aged 2 to 3 attending some form of early childhood care and education programs. For older children, the number attending educational programs is even greater. In 1996-97, 513,000 (64%) children 4 and 5 years of age attended kindergarten, 198,000 (25%) attended some form of early childhood care and educational programs, and 85,000 (11%) remained at home.

The Government of Canada continues to help parents offset the cost of childcare through the Child Care Expense Deduction. The 1998 budget increased the Child Care Expense Deduction in the personal income tax system from $5,000 to $7,000 for children under age seven and from $3,000 to $4,000 for children age 7 to 16.

The First Nations/Inuit Child Care Program was introduced in 1995, and has created or improved 7,000 quality child care spaces on reserve and in Inuit communities. The program is managed and delivered by First Nations and Inuit peoples, with financial support from the Government of Canada of $41 million per year.

#### *Education and Literacy*

Under provincial government law, education is mandatory in Canada, in most cases up to a secondary level that corresponds to children 14 to 18 years old. With respect to primary school, Canada enjoys a high percentage of children entering first grade of primary school who eventually reach grade 5. From 1986 to 1993, this rate was 96%, and it increased to 99% during the 1990-1995 period. Similarly, the proportion of children of primary school age enrolled in primary school is also high, although a slight decrease can be observed since the mid 1980s. From 1993-1995, 96% of males and 94% of females of primary school age were enrolled in primary school. Factors such as improved data collection, estimates in non-census years and technical changes to the definition of schooling may have contributed to this observed decline.

The Government of Canada introduced a new initiative to improve access to post-secondary education and minimize student debt loads upon graduation. The Canada Education Savings Grant (CESG) provides an incentive for individuals to save in Registered Education Savings Plans (RESP). The grant provides an additional 20 per cent up to $400 per year on the first $2,000 saved each year in an RESP for Canadian children aged 0-17. Its aim is to encourage families to prepare their children from an early age for the financial, social, and academic aspects of post-secondary education. Since the inception of the program, the number of RESP contracts has more than doubled and the number of beneficiaries has been increasing steadily. By March 2000 15% of Canadian children were beneficiaries of an RESP and 1.1 million beneficiaries were receiving grant. Savings in RESPs increased from $2.4 billion in 1997 to $6 billion by the end of 1999, a 150% increase in assets. CESG is delivered in co-operation with the financial services industry and several Government of Canada departments.

Status Indians realized steady gains in educational achievement between 1991 and 1996, both on and off-reserve. The total number of on-reserve children enrolled in kindergarten, elementary and secondary schools increased by 37 per cent between 1988-89 and 1998-99. More Status Indians are completing their education. For Status Indians the percentage with university degrees increased from 2.0 per cent in 1991 to 3.0 per cent in 1996. The number of Status Indians and Inuit enrolled in post-secondary institutions almost doubled between 1988-89 and 1998-99. The post-secondary enrolment rate for Status Indian population aged 17-34 remained constant from 1994-95 to 1997-98. In 1996, of the Status Indian population 15 years and over attending school, 80.5 per cent were attending full-time - 10 per cent more than the total Canadian population.

Literacy skills are essential for full participation in today's world. The education and literacy of parents can have a positive impact on a child's educational achievement. Canada generally enjoys a high rate of adult literacy, and in 1995 reached a proportion of 97% among the population aged 15 years and older who are able to read and write a general statement about their everyday life.

### *4.7 Children in Especially Difficult Circumstances*

The range of situations which describe children "living in especially difficult circumstances" is diverse. These situations go far beyond those described in this section, and include children who are sexually exploited, refugee children, children in care of the state, the sale and trafficking of children, and others. What is common to all of these children is that they experience situations that represent an obstacle to, or that serve to compromise, their rights, well-being and development. Effective government action

can serve to reduce the impact of these difficult circumstances on children, emphasize prevention by working with those children at risk of experiencing those difficult circumstances, or employ a combination of these approaches.

***Aboriginal Children***

The differences in socio-economic conditions between Status Indians, Status Indians living on-reserve and the total Canadian population are apparent both within First Nations communities and throughout the larger population of Canada. The gap continues to narrow, however, between these groups. An improvement toward narrowing the earnings gap was realized between 1990 and 1995. For Status Indians living on-reserve, an increase was noted for those who completed trades or non-university training between 1991 and 1996. Within the Status Indian population, women's employment earnings as a percentage of men's rose between 1990 and 1995. For statistics regarding the educational achievement of Aboriginal People, see Section 4.6. In other areas, important challenges to progress still remain. In a study of a First Nation community in Manitoba, Fetal Alcohol Syndrome and Fetal Alcohol Effect rates were estimated at 10 to 30 times the world wide incidence. Also, First Nations children were five times more likely to be in the care of Child and Family Service (CFS) agencies than the national average in 1996-1997. The ratio of on-reserve Status Indian children in care to on-reserve Status Indian children aged 16 and under has remained stable for the last five years. Finally, suicide among Aboriginal people is three times the rate for non-Aboriginal people. Suicide rates for First Nation females aged 15 to 24 years are eight times higher than the national rate among females of the same age cohort. For some examples of measures taken by the Government of Canada with respect to Aboriginal People, see Section 3 "Action at the National Level."

***Children in Care***

Canada as a whole does not have a uniform definition of a "child in care", since the reason a child may be taken into care varies between provincial/territorial jurisdictions. Generally children taken into care are children who, as a result of abuse and/or neglect, have had provincial or territorial child welfare authorities assume responsibility for them on a temporary or permanent basis.

In March 1990, there were approximately 30,180 children in care (excluding data from the province of Quebec, which was not available). In March 1999, there were approximately 41,940 children in care (excluding data from the province of Quebec). Estimated data from that province has only become available as of March 1998 – the most recent data indicates that there are 20,510 children in care in Quebec, giving a Canada-wide total of 62,450 children in care for 1999.

***Children with Disabilities***

Examples of human rights legislation in Canada point to the need to reasonably accommodate disabled persons, including children. Over the past 10 years, there has been a small change in the proportion of Canadian children with disabilities. In 1991, the proportion of Canadians under 19 years who had an activity limitation or disability was 7.2%. By 1996-1997, this proportion had risen to 7.7%. In

First Nation communities, disability rates are twice the national average. Action on behalf of persons with disabilities is an ongoing priority of governments across Canada. Recent actions by the federal government for Canadians with disabilities have included enhancements to educational grants, housing loans and grants, employment assistance and a range of tax credits.

***Sexually Exploited Children***

Combating the sexual exploitation of children is a responsibility that is shared in Canada by several levels of government and numerous non-governmental agencies and organizations. The Government of Canada, through the work of a federal interdepartmental committee, is developing and promoting a Canadian strategy in response to the Declaration and Agenda for Action from the *First World Congress Against Commercial Sexual Exploitation of Children* held in Stockholm in 1996. The strategy includes child participation, prevention, protection, recovery/reintegration, information collection and dissemination, international cooperation and follow-up. The committee issues and updates a report listing federal government activities that work to eliminate the commercial sexual exploitation of children. One of the most important elements of Canada's national strategy is opening and maintaining channels of communication.

In May 1997, Bill C-27 amended the *Criminal Code* to allow for the Canadian prosecution of persons who engage in child sex tourism in foreign countries and to facilitate the apprehension and prosecution of persons who seek out the services of juvenile prostitutes in Canada. The Bill also provides for a mandatory minimum sentence of five years imprisonment for any person living off the avails of a child prostitute, and who uses violence against the person under that age and assists that person in carrying on prostitution-related activities for profit.

The federal government has initiated a consultation process through the Federal-Provincial-Territorial Continuing Committee of Officials on Human Rights to examine any necessary implementation measures for the *Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography* for federal, provincial, and territorial jurisdictions, with a view to Canada's future signature and ratification of this instrument.

***Children, Youth and Work***

Exploitative work, or any work that places the development or education of a child at risk, is not considered to be a domestic challenge in Canada. Legislation exists in Canadian provinces restricting work by children under a given age, in most cases under the age of 14 or 15 years. The Government of Canada also places restrictions on employment of children under 17 years in federal workplaces. In all of these statutes, emphasis is placed on restricting all work that interferes with the required schooling of children under provincial law.

The proportion of youth aged 15 to 19 who participated in the labour force in Canada decreased from 59% (males) and 56% (females) in 1990 to 48.1% (males) and 46.6% (females) in 1996, and most recently remained stable with a slight increase, at 48.3% (males) and 47.9% (females) in 1998. The

majority of these work situations are rewarding, giving young people access to a range of new experiences and information on their personal and career development from a variety of sources. These experiences promote rather than challenge children's rights.

Canada is nonetheless conscious of the threat of exploitative child labour both domestically and internationally, and is committed to taking relevant action to prevent and address the harmful employment of children. To this end, Canada ratified *ILO Convention No. 182 on the Elimination of the Worst Forms of Exploitative and Child Labour* on June 6, 2000, following consultations with provinces and territories as well as with employers' and workers' organizations. The Convention calls for the elimination of the worst forms of child labour such as all forms of slavery (including debt bondage and the forced recruitment of children for use in armed conflict), the use of children for prostitution, pornography, and drug trafficking, and work which is likely to harm the health, safety or morals of children.

At the time of ratification, Canada announced that it would provide $15 million over 5 years ($3 million per year) to the International Labour Organization (ILO) for programs on the elimination of child labour. Three million dollars of this amount has already been targeted to the Statistical Information and Monitoring Program on Child Labour (SIMPOC), an ILO program aimed at assisting 50 member countries to generate comprehensive data on all forms of child labour in order to improve understanding of the problems in order to better target efforts at its elimination. Over the next four years, funding in the amount of $12 million will continue to be directed at ILO programs aimed at eliminating child labour.

### *4.8 Children in Armed Conflict and Peacebuilding*

Among the most urgent objectives for human security is the protection of war-affected children. In the past decade, almost two million children have been killed in armed conflict, more than four million disabled and more than one million orphaned. Over 10 million children have been psychologically scarred by the trauma of abduction, detention, sexual assault and the brutal murder of family members.

Their plight is a central concern for Canada 's foreign policy. For this reason, Canada played a leadership role in the negotiation and adoption of the *Optional Protocol to the Convention on the Right of the Child on Involvement of Children in Armed Conflict*, Canada was the first country to sign and ratify the *Optional Protocol* in June and July 2000, respectively. In taking this initiative the federal government worked in consultation with the Department of National Defence to amend Section 34 of the *National Defence Act* (Bill S-18) to entrench into law the Canadian Forces' policy precluding persons under the age of 18 from deployment to hostile theatres of operations. Canada will continue to promote the Optional Protocol's wide ratification and implementation internationally, in order to expedite its rapid entry into force and to put a stop to the compulsory recruitment and deployment of child soldiers.

As part of these efforts, Canada hosted over 800 delegates at the first ever International Conference on War-Affected Children, in Winnipeg, from September 10 to 17, 2000. Youth participation was a key objective and success of this conference. The youth delegates began with their own closed sessions and then participated as full delegates in both the Expert and Ministerial level conference meetings. The Experts meeting, which brought together governments, NGOs, researchers, representatives of media and the private sector and youth, came up with a number of forward-looking recommendations

for action by different actors in the international community. Key themes that emerged from the conference included: the importance of education in overcoming many of the challenges faced by war-affected children both in terms of rehabilitation as well as peacebuilding; conflict prevention; the relationship between HIV/AIDS, conflict and children; the need to end impunity and increase accountability; the resilience of youth and the important role that youth must play in reconstruction and peacebuilding. The Ministerial-level meeting attended by over 40 ministers and representatives from 132 governments, resulted in endorsement by governments of an international Agenda on War-Affected Children. A steering committee has been established to guide and monitor the follow-up to the international conference. In addition, the outcomes of the conference will contribute to the 2001 UN Special Session on Children.

In April 2000, Canada and Ghana co-hosted the Conference on War-Affected Children in West Africa, which demonstrated how key actors can commit to action across the range of problems faced by war-affected children. Through existing bilateral, regional and multilateral networks, Canada is an active player amongst a growing number of countries committed to war-affected children, and is working to mainstream this issue within the UN system, the OAS, the OSCE, the OAU, and the Economic Community of West African States (ECOWAS). Within regional organisations, Canada has been a strong advocate for the establishment of child protection focal points. Within the UN, Canada supports the Special Representative of the Secretary-General for Children and Armed Conflict and United Nations agencies, in particular UNICEF and the UNHCR. In the Security Council, Canada has identified the issue of war-affected children as a key element in initiatives to promote the protection of civilians in armed conflicts, and has strongly supported Security Council initiatives to incorporate the needs of children into peace support operations and peacekeeping training.

Since 1995, the Canadian International Development Agency's (CIDA) International Humanitarian Assistance has provided over $25 million for activities focused directly on children affected by armed conflict. Other projects have been carried out by CIDA's bilateral country programs in collaboration with Canadian-based NGOs and other organizations such as UNICEF and the Red Cross. Projects have also been funded through the Canada Fund for Local Initiatives in collaboration with local NGOs. In addition, CIDA has supported the work of the Office of the Special Representative of the Secretary General for Children and Armed Conflict, encouraging collaboration with other UN agencies and offices; has produced *A Programming Framework for Children Affected by Armed Conflict,* which provides guidance in program development; and has compiled *A Survey of Canadian Programming Experience with Children Affected by Armed Conflict* which profiles the experience of Canadian partners with children affected by conflict by sector (health, education, etc.) and geographic focus.

Canada, in cooperation with several other states and non-governmental organizations, played a leading role in initiating and bringing into force the *Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on Their Destruction.* Canada views the Convention as the most appropriate framework for addressing the global scourge of anti-personnel mines and in ensuring the eventual elimination of this indiscriminate weapon. Canada was the first country to sign and ratify this Convention in December 1997.

The *Anti-Personnel Mines Convention Implementation Act* -- the legislation implementing the *Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and Their Destruction* -- received Royal Assent on November 27, 1997. The Act prohibits the development, production, acquisition, possession, transfer, stockpiling and placement of anti-personnel mines and requires the Government of Canada to destroy anti-personnel mines stockpiled by Canada (although the destruction of stockpiles was completed prior to the Act being approved by Parliament).

In 1998, Canada established a five-year fund to support programming consistent with the aims of the Convention. To date, Canada has disbursed millions of dollars from this fund to support mine clearance and related survey activities, victim assistance and mine awareness programs in every mine-affected region in the world. In addition, Canada has provided funding to the international non-governmental community to support sustainable activity leading to the eventual universalization of the new international norm suggested by the Convention.

### *4.9 Environmental Protection*

There is growing evidence that many children's health problems are caused or exacerbated by environmental pollution, and that children's exposure to environmental hazards are different and often greater than those of adults. The developing fetus, infants and children are in a state of rapid growth, with cells multiplying and organ systems (such as the brain, liver, and immune systems) developing at faster rates than at any other time in life. Environmental toxins disrupt these complex processes and can cause illness, disabilities, and premature death. Children have a higher intake of air, water and food in relation to their body weight, which may have a tendency to result in the disproportionate impact of environmental hazards.

Environmental protection, sustainable development, and the environmental health of children are high priorities for the Government of Canada. The Government of Canada has undertaken several initiatives to address issues surrounding children's environmental health. In 1997, Canada signed the Miami Declaration along with other G8 countries, which addressed methods for risk assessment and standards setting, lead, microbiologically safe drinking water, endocrine-disrupting chemicals, environmental tobacco smoke, and air quality. Also, Canada supported in principle the 1999 European Ministers Declaration sponsored by the WHO that includes commitments to children's health and the environment. More recently, Canada committed to developing a long-term cooperative agenda with Mexico and the U.S. to address issues pertaining to children's environmental health, under the North American Commission for Environmental Cooperation.

The Government of Canada is also committed to furthering inter-sectoral cooperation and to working with NGO's to address children's environmental health. In 1996, the federal government, along with representatives from a variety of organizations, the private sector, and academia, participated in a program launched by the Canadian Institute of Child Health (CICH), which included a National Symposium, research and education on children's health and the environment. In the summer of 2000, the Government of Canada hosted the workshop "Our Children, Our Health: Towards a Children's Environmental Health Agenda" to identify priority areas for action.

Environmental hazards have been linked to most of the leading causes of deaths, illnesses and hospitalizations for Canadian children (age 0-19 years), including low birth weight and birth defects, unintentional injuries, cancer, sudden infant death syndrome (SIDS), respiratory infections, and asthma. Over the past 20 years, there has been a fourfold increase in the childhood prevalence of asthma, with 12% of Canadian children (aged 0-19) now experiencing asthma, and 29,000 children being hospitalized each year. In addition, exposure to tobacco smoke in the home is responsible for a variety of health issues for children. In Canada, 33% of children under 12 are regularly exposed to tobacco smoke in their home. Further, children's exposure to polluted water, pesticides, organic pollutants, and other chemicals may have serious developmental effects to their endocrine and immune systems.

Some improvements have been made in relation to the levels of toxins in the environment. Canada has reduced blood lead levels for children and adults to rank among the lowest for developed countries: from 11.9 micrograms per litre in 1984 to 3.5 micrograms per litre in 1992. Carbon dioxide emissions have also been reduced in Canada. Between 1989 and 1994, the per capita carbon dioxide emissions from fossil fuel combustion have fallen from 16.55 tonnes to 15.65 tonnes.

There remains a need for coordinated, integrated and comprehensive research to determine the precise nature of the relationship between environmental hazards and children's health. The Government of Canada has committed to developing and implementing measures to address children's environmental health issues, and will continue to do so in the future.

## *5. Lessons Learned*

Actions taken for children in the last 10 years have given Canada a range of important experiences involving what interventions are most effective and how government action should best be structured for children.

The first lesson learned that can be applied to future initiatives for children is that *effective action for children requires heightened coordination across government departments and among governments.* In addition to being a major finding in the evaluation of the Brighter Futures initiative, improved coordination within and among governments is relevant to numerous other initiatives where program goals are multi-sectoral and varied, as are children's needs. In Canada, responsibility for the well-being of children is shared within the federal government by numerous relevant departments. As mentioned earlier, responsibility is also shared among federal, provincial and municipal governments who each play distinct and complementary roles in supporting children and families. There is a continuing need to enhance interdepartmental cooperation within the Government of Canada to improve the effectiveness of actions taken for children.

With regard to the effectiveness of various government actions for children, experience has shown that *strong, broad-based social investments, coupled with an additional focus on prevention among children most at risk*, can improve the well-being of children and offset the effects of poverty and inequality. A sustainable health care system, accessible to all Canadian children, remains the most important investment in the health of Canadian children. Equally important for child development is the accessibility and quality of public education. These universal programs are often complemented by more specific initiatives aimed at those at risk of not reaching optimal levels of health and development. Together, universal and targeted approaches allow governments to reach all citizens, and to give special attention to those who are in greatest need.

Throughout the decade of the 1990s, significant attention has been given to child and family poverty in Canada. Throughout this time, addressing the causes and lessening the impact of low income for families with children has been a priority of the Government of Canada as well as of the provincial and territorial governments. As described in greater detail in Section 4, while actions taken have been extensive, results have been varied. The experience of the 1990s has shown that *a complex mix of factors leads to poverty* and that a broad combination of actions, addressing the full range of a child's development, is required to address poverty's impact on children and families. This comprehensive approach to addressing poverty has influenced government action, and is apparent in measures described throughout this report and in particular sections 3 and 4.5.

A young person's right to have a say in decisions that affect him or her is recognized by the *Convention on the Rights of the Child*. Canada has integrated principles of youth participation in initiatives related to community and economic development, youth health, environmental protection, youth justice, sexual exploitation, international development and the promotion of cultural diversity. These initiatives have generated important lessons about the most appropriate and effective ways to facilitate participation by young people, and the need to further advance the involvement of youth. Among these, it has been seen that *peer role models, young adult resource persons, and child-to-child techniques* are effective means to enrich the participation of children; that *youth learn best "by doing"*, by participating actively and directly rather than being told what to do; that once they are involved, *youth tend to move on to broader community affairs, multiplying the benefits of their initial involvement* throughout their community; and that for participation to work, *youth must be able to express their opinions and their creativity freely*.

A child's diverse needs are fulfilled by many actors, but as the *Convention on the Rights of the Child* indicates, parents and family play the primary role in providing the care and nurturing needed for healthy physical, moral, social and spiritual development. Through its many initiatives for children, Canada has come to understand *the importance of parental and family involvement*. It seeks to apply this principle so that parents are able to support their children, and equally so that governments are able to find effective ways to assist parents in their role.

Beyond the roles played by parents, families and governments, there is a broad and rich diversity of actors who affect children's well-being. *Governments have learned that facilitating partnerships across this diversity of actors is a powerful tool in developing innovative approaches to meet children's needs*. Partnerships involving different levels of government, municipalities, voluntary sector organizations, professional associations, schools and the private sector are found in such areas as health, child safety, community development, recreation, arts and culture, education and in facilitating youth participation.

Important lessons have also been learned with regard to ensuring the well-being of the Aboriginal Peoples of Canada. The Aboriginal population is subject to national economic trends and fluctuations. In addition, the relative isolation of many First Nations communities constrains economic opportunities. *Improving income security provides more opportunities for Aboriginal Peoples*. For example, as part of the Government of Canada's Aboriginal Action Plan, *Gathering Strength*, the Aboriginal Human Resource Development Strategy creates full partnerships between the federal government and Aboriginal communities. Aboriginal agreement holders under the Strategy are enabled to design and deliver labour market programming, child care initiatives, and job readiness programming to help ensure Aboriginal Canadians have access to labour market opportunity, and access thus to improved standards of living.

Second, *increasing the capacity for Aboriginal institutions to provide care and nurturing of children in their own community* reinforces culturally appropriate demonstrable growth in community capacity. Working in partnership with Aboriginal organizations and communities, steps will be taken to help improve the health and social outcomes and public safety of Aboriginal children. By expanding programs directed towards Aboriginal children and families and working with Aboriginal organizations and communities, appropriate solutions can be developed to address the specific and pressing needs of Aboriginal children.

## *6. Summary*

The Government of Canada is committed to the goals of the World Summit for Children, and since 1990 has taken a range of actions to implement the rights and enhance the well-being of children. Through the collective efforts of Canadians and all levels of government, Canada has made progress with respect to many of the goals of the World Summit, and will continue to work in Canada and abroad to ensure that the Summit's ideals are realized.

Canada's efforts with respect to achieving the goals of the World Summit have included actions to improve children's security, safety, health and development, and to promote the implementation of their rights under the Convention on the Rights of the Child. Some specific initiatives undertaken by governments have included improving early childhood development; expanding immunization coverage; increasing children's access to information through the Internet; strengthening the protection of children living in especially difficult circumstances; and increasing economic support for children and their families. While progress has been achieved in these and other areas, there remains a need to work together toward ensuring and enhancing the well-being of Canada's children and the children of the world.

Future action for children will be informed by the principles of the Convention on the Rights of the Child, and will build on the many lessons learned from the experiences of communities, voluntary associations and governments over the past decade. The wealth of these experiences and commitments will serve to strengthen Canadians' efforts to ensure the well-being, protection and participation of children and youth into the new millennium.

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# Appendices

## Appendix 1

### GLOBAL INDICATORS FOR MONITORING PROGRESS AT END-DECADE
**Progress Report for Canada**

**Note:** In Appendix 1, "N/A" is used when indicators are "not applicable", especially those which are most relevant to developing countries. In those sections where the symbol "-" is used, it is to indicate either that statistics are not officially compiled or that national surveys or other data collection methods do not exist for the given indicator. "Alternate indicators" are comparable indicators that will be used when the specific indicators requested are unavailable or not collected.

| | **Goal** | **Description** | **1990** | **1996** | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| 1 | Reduction of infant and under-five child mortality rate by one-third or to 50 and 70 per 1000 live births respectively, whichever is less. | | | | | |
| | *Under-Five Mortality Rate* | Probability of dying between birth and exactly five years of age, per 1000 live births. | 9 | 7 | 1998 - 6 | 33.3% decrease |
| | *Infant Mortality Rate* | Probability of dying between birth and exactly one year of age, per 1000 live births 34. | 6.8<br><br>First Nations: | 5.6 | 1997 - 5.5<br>1998 - 6 | 19% decrease |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | | | 11.2 | 1994 - 11.98 | - | 7% increase |
| 2 | Reduction of maternal mortality rate by half | | | | | |
| | *Maternal Mortality Ratio (MMR)* | Annual number of deaths of women from pregnancy related causes, when pregnant or within 42 days of termination of pregnancy, per 100,000 lives births. | 6 | 1995- 4 | Less than 5 per 100,000 births in the 1990s | 33.3% decrease |
| 3 | Reduction of severe and moderate malnutrition among under-five children by half | | | | | |
| | *Underweight prevalence* | Proportion of under-fives who fall below minus 2 and below minus 3 standard deviations from median weight for age of NCHS/WHO reference population. | N/A | N/A | N/A | |
| | *Stunting prevalence* | Proportion of under-fives who fall below minus 2 and below minus 3 standard deviations from median height for age of NCHS/WHO | N/A | N/A | N/A | |

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| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | | reference population. | | | | |
| | *Wasting prevalence* | Proportion of under-fives who fall below minus 2 and below minus 3 standard deviations from median weight for height of NCHS/WHO reference population. | N/A | N/A | N/A | |
| 4 | Universal access to safe drinking water. | | | | | |
| | *Use of safe drinking water* | Proportion of population who use any of the following types of water supply for drinking: (1) piped water; (2) public tap; (3) borehole/pump; (4) well (protected/covered); (5) protected Spring | - <u>First Nations:</u> 1987-88 - 82% of houses on First Nations Reserves had adequate water supply. | - 1996-97 - 96.1% houses on First Nations Reserves had adequate water | 1998 - 99% Access to adequate safe water within a convenient distance from the user's dwelling. | |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | | | | supply. | | |
| 5 | Universal access to sanitary means of excreta disposal | | | | | |
| | *Use of Sanitary means of excreta disposal.* | Proportion of population who have, within their dwelling or Compound: (1) toilet connected to sewage system; (2) any other flush toilet (private or public); (3) improved pit latrine; (4) traditional pit latrine. | 1987-88 - 72% First Nations reserves had sewage disposal systems. | 1996-97 - 91.5% First Nations reserves had sewage disposal systems. | - | 19.5% increase |
| 6 | Universal access to basic education, and achievement of primary education by at least 80 per cent of primary school-age children through formal schooling or non-formal education of comparable learning standard, with emphasis on reducing the current disparities between boys and girls. | | | | | |
| | *Children reaching grade 5* | Proportion of children entering first grade of primary school who eventually reach grade 5. | 1986-93 - 96% | - | 1990-95 - 99% | 3% increase |
| | *Net primary school* | Proportion of children of primary | 1986-92 - | - | 1993-1995 - | 3% |

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| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | *enrolment ratio* | school age enrolled in primary school.* | males 99<br>females 98 | | males 96<br>females 94 | decrease 4%<br>decrease |
| | *Net primary school attendance rate* | Proportion of children of primary school age attending primary school. | - | - | - | |
| 7 | Reduction of the adult illiteracy, with emphasis on female literacy. | | | | | |
| | *Literacy Rate* | Proportion of population aged 15 years and older who are able, with understanding, to both read and write a short simple statement on their everyday life. | 1990 - 97% | 1995 - 97% | - | No change |
| 8 | Provide improved protection of children in especially difficult circumstances and tackle the root causes leading to such situations. | | | | | |
| | *Disability Screening* | Estimated percentage of children 0-12 | | | | |

* Further explanation/information on this statistic is being pursued. Any new information will be reported accordingly.

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | | who have been screened for one or more disabilities by a certified screening body. | - | - | - | |
| | *Total child disability rate* | Proportion of children aged 5-14 years with some reported physical or mental disability. | 1991 - 7.2% (child 0- 19 yrs) | - | 1996-97 - 7.7% had activity limitation or disability between birth and 19 yrs. | Data not compari-ble |
| 9 | Special attention to the health and nutrition of the female child and to pregnant and lactating women | | | | | |
| | *Under-five mortality rate* | Probability of dying between birth and exactly five years of age, per 1000 live births | see #1 above | | | |
| | *Underweight prevalence-male/female* | Proportion of under-fives who fall below minus 2 standard deviations from median weight for age of NCHS/WHO reference population | N/A | N/A | N/A | |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
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| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | *Antenatal care* | Proportion of women aged 15-19 who attended at least once during pregnancy by skilled health personnel | N/A | N/A | N/A | |
| | *HIV Prevalence* | Proportion of AIDS cases among adult women.<br><br>Number of adult AIDS cases, disaggregated by gender. | <1990 - 5.6% AIDS cases among adult women.<br><br>1990 - Female: 64 Male: 1,347 | 1994 - 7.7% AIDS cases among adult women.<br><br>1994 - Female: 131 Male: 1,556 | 1999 - 16.3% AIDS cases among adult women.<br>1999 - Female: 41 Male: 208 | 11.8% increase |
| | *Anaemia* | Proportion of women aged 15-19 year with haemoglobin levels below 12 grams/100 ml. Blood for non-pregnant women and below 11 grams/100 ml. Blood for pregnant women | N/A | N/A | N/A | |
| 10 | Access by all couples to information and services to prevent pregnancies that are too early, too closely spaced, too late or too many. | | | | | |
| | *Contraceptive Prevalence* | Proportion of women aged 15-49 who are using (or whose partner is using) a | 1980-94 - 73% | - | 1990-99 - 73% | No change |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | | contraceptive method (either modern or traditional) | | | | |
| | *Fertility Rate for women 15-19* | Number of live births to women aged 15-19 per 1000 women aged 15-19 | 1991-25.98 | 1995-24.49<br>1996-22.34 | 1997-20.19 | 22% decrease |
| | *Total fertility rate* | Average number of live births per woman who has reached the end of her child bearing period. | 1990 - 1.7 | 1996 - 1.6 | 1997 - 1.6 | Decrease 5.9% |
| 11 | Access by all pregnant women with access to pre-natal care, trained attendants during childbirth, and provide care and attention in cases of high-risk pregnancies and obstetric emergencies. | | | | | |
| | *Antenatal Care* | Proportion of women aged 15-49 attended at least once during pregnancy by skilled health personnel. | N/A | N/A | N/A | |
| | *Childbirth care* | Proportion of births attended by skilled health personnel | 1983-93 - 99% | - | 1990-97 - 99% | No change |
| | *Obstetric care* | Number of facilities providing comprehensive essential obstetric care per 500,000 population. Number of facilities providing basic essential | - | - | - | |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
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| 11 | Access by all pregnant women with access to pre-natal care, trained attendants during childbirth, and provide care and attention in cases of high-risk pregnancies and obstetric emergencies. | | | | | |
| | *Antenatal Care* | Proportion of women aged 15-49 attended at least once during pregnancy by skilled health personnel. | N/A | N/A | N/A | |
| | *Childbirth care* | Proportion of births attended by skilled health personnel | 1983-93 - 99% | - | 1990-97 - 99% | No change |
| | *Obstetric care* | Number of facilities providing comprehensive essential obstetric care per 500,000 population. Number of facilities providing basic essential | - | - | - | |

| | **Goal** | **Description** | **1990** | **1996** | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | | obstetric care per 500,000 population. | | | | |
| 12 | Reduction of the low birth weight (less than 2.5 kg) rate to less than 10 per cent. | | | | | |
| | *Birth weight below 2.5 kg.* | Proportion of live births that weigh below 2500 grams. | 1990 - 5.4%<br>1991 - 5.6%<br><br>1990 -<br>Males 6.0%<br><br>Females 5.1% | 1995 - 5.7%<br>1996 - 5.8%<br><br>1995 -<br>Males 6.1%<br><br>Females 5.3% | - | 0.4% increase<br><br>0.1% increase<br><br>0.2% increase |
| 13 | Reduce Iron Deficiency Anaemia (In Women) by One-Third of the 1990 levels | | | | | |
| | *Anaemia* | Proportion of women aged 15-49 with haemoglobin levels below 12 grams/100ml blood for non-pregnant women, and below 11 grams/100ml blood for pregnant women. | N/A | N/A | N/A | |
| 14 | Virtual elimination of iodine deficiency disorders | | | | | |
| | | | | | | |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | Iodized salt consumption | Proportion of households consuming adequately iodized salt. | N/A | N/A | N/A | |
| | Low urinary iodine | Proportion of population (school age children or general population) with urinary iodine levels below 10 micrograms/100ml urine. | N/A | N/A | N/A | |
| 15 | Virtual elimination of vitamin A deficiency (VAD) and its consequences, including blindness. | | | | | |
| | *Children receiving vitamin A supplements* | Proportion of children 6-59 months of age who have received a high dose vitamin A supplement in the last 6 months. | N/A | N/A | N/A | |
| | *Mothers receiving vitamin A supplements* | Proportion of mothers who received a high dose vitamin A supplement before infant was 8 weeks old. | N/A | N/A | N/A | |
| | *Low vitamin A* | Proportion of children 6-59 months of age with serum retinol below 20 micrograms/100ml. | N/A | N/A | N/A | |
| 16 | Empowerment of all women to breast-feed their children exclusively for four to six months and to continue breast-feeding, | | | | | |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | | obstetric care per 500,000 population. | | | | |
| 12 | Reduction of the low birth weight (less than 2.5 kg) rate to less than 10 per cent. | | | | | |
| | *Birth weight below 2.5 kg.* | Proportion of live births that weigh below 2500 grams. | 1990 - 5.4%<br>1991 - 5.6%<br><br>1990 -<br>Males 6.0%<br><br>Females 5.1% | 1995 - 5.7%<br>1996 - 5.8%<br><br>1995 -<br>Males 6.1%<br><br>Females 5.3% | - | 0.4% increase<br><br>0.1% increase<br><br>0.2% increase |
| 13 | Reduce Iron Deficiency Anaemia (In Women) by One-Third of the 1990 levels | | | | | |
| | *Anaemia* | Proportion of women aged 15-49 with haemoglobin levels below 12 grams/100ml blood for non-pregnant women, and below 11 grams/100ml blood for pregnant women. | N/A | N/A | N/A | |
| 14 | Virtual elimination of iodine deficiency disorders | | | | | |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | Iodized salt consumption | Proportion of households consuming adequately iodized salt. | N/A | N/A | N/A | |
| | Low urinary iodine | Proportion of population (school age children or general population) with urinary iodine levels below 10 micrograms/100ml urine. | N/A | N/A | N/A | |
| 15 | Virtual elimination of vitamin A deficiency (VAD) and its consequences, including blindness. | | | | | |
| | *Children receiving vitamin A supplements* | Proportion of children 6-59 months of age who have received a high dose vitamin A supplement in the last 6 months. | N/A | N/A | N/A | |
| | *Mothers receiving vitamin A supplements* | Proportion of mothers who received a high dose vitamin A supplement before infant was 8 weeks old. | N/A | N/A | N/A | |
| | *Low vitamin A* | Proportion of children 6-59 months of age with serum retinol below 20 micrograms/100ml. | N/A | N/A | N/A | |
| 16 | Empowerment of all women to breast-feed their children exclusively for four to six months and to continue breast-feeding, | | | | | |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | with complementary food, well into the second year. | | | | | |
| | *Exclusive breast-feeding rate* | Proportion of infants less than 4 months (120 days) and less than 6 months (180 days) of age who are exclusively breast-fed. | 1990 - 43% (15 and older) women breast-fed their child. | 1994-95 - 73% national initiation rate. | 1996-97 - 79% (15-49) of moms breast-fed. | Data not compari-ble |
| | *Timely complementary feeding rate* | Proportion of infants 6-9 months (180 to 299 days) of age who are receiving breast milk and complementary food. | - | - | - | |
| | *Continued breast-feeding rate* | Proportion of children 12-15 months and 20-23 months of age who are breast-feeding. | 1994 - 69% (Children under age 2 who were ever breast-fed) | 1996 - 77% | - | 8% increase |
| | *Number of baby-friendly facilities* | Number of hospitals and maternity facilities that are designated as baby-friendly according to global BFHI criteria. | 0 | 0 | 1 | increase |
| 17 | Growth promotion and its regular monitoring to be institutionalized in all countries by the end of the 1990s. | | | | | |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | *No specific indicator(s)*<br>*Growth chart coverage* | Proportion of children up to 2 years of age who have growth card | - | - | - | |
| | *Growth Monitoring coverage* | Proportion of children up to 2 years of age who have growth card | - | - | - | |
| | *Obesity* | Proportion of children 0-5 who are clinicaity obese. | - | - | - | |
| | *Alternate indicator* | Proportion of children in grades 4 and 9 who are clinically obese | 1981-<br>14% girls<br>18% boys<br><br>1991 -<br>24% girls<br>26% boys<br>(1981-1991) | - | - | |
| 18 | Dissemination of knowledge and supporting services to increase food production to ensure household food security. | | | | | |
| | *No specific indicator(s)* | | | | | |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | with complementary food, well into the second year. | | | | | |
| | *Exclusive breast-feeding rate* | Proportion of infants less than 4 months (120 days) and less than 6 months (180 days) of age who are exclusively breast-fed. | 1990 - 43% (15 and older) women breast-fed their child. | 1994-95 - 73% national initiation rate. | 1996-97 - 79% (15-49) of moms breast-fed. | Data not compari-ble |
| | *Timely complementary feeding rate* | Proportion of infants 6-9 months (180 to 299 days) of age who are receiving breast milk and complementary food. | - | - | - | |
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| | *Number of baby-friendly facilities* | Number of hospitals and maternity facilities that are designated as baby-friendly according to global BFHI criteria. | 0 | 0 | 1 | increase |
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| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | *No specific indicator(s)* *Growth chart coverage* | Proportion of children up to 2 years of age who have growth card | - | - | - | |
| | *Growth Monitoring coverage* | Proportion of children up to 2 years of age who have growth card | - | - | - | |
| | *Obesity* | Proportion of children 0-5 who are clinically obese. | - | - | - | |
| | *Alternate indicator* | Proportion of children in grades 4 and 9 who are clinically obese | 1981- 14% girls 18% boys<br>1991 - 24% girls 26% boys (1981-1991) | - | - | |
| 18 | Dissemination of knowledge and supporting services to increase food production to ensure household food security. | | | | | |
| | *No specific indicator(s)* | | | | | |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | Hunger among Canadian Families | Percentage of Canadian families who went without food at least once in one year because of a lack of money or food | - | 1994 - 1.2% or 57,000 families | - | |
| | Children in families using food banks | Percentage of children living in families using food banks, among total food bank users | - | - | 2000 - approx. 40% | |
| 19 | Eradication of poliomyelitis. | | | | | |
| | *Polio Cases* | Annual number of cases of polio. | 1988 - 0 | 1996 - 0 | 1998 - 0 | No change |
| 20 | Elimination of neonatal tetanus by 1995 | | | | | |
| | *Neonatal tetanus cases* | Annual number of cases of neonatal tetanus | N/A | N/A | N/A | |
| 21 | Reduction by 95 per cent in measles deaths and reduction by 90 per cent of measles cases compared to pre-immunization levels by 1995, as a major step to the global eradication of measles in the long run. | | | | | |
| | *Under five deaths from* | Annual number of under-five deaths | - | - | - | |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | *measles* | due to measles. | | | | |
| | *Measles Cases* | Annual number of cases of measles in children under five years of age. | 1994 - 523 | 1996 - 332<br>1997 - 581 | 1998 - 12 | 97.7% decrease |
| 22 | Maintenance of a high level of immunization coverage (at least 90 per cent of children under one year of age by the year 2000) against diphtheria, whooping cough, tetanus, measles, poliomyelitis, tuberculosis and against tetanus for women of child-bearing age. | | | | | |
| | *DPT immunization Coverage* | Proportion of one year old children immunized against diphtheria, pertussis and tetanus (DPT) | 1994 - 82.3% | 1997 - 85% | 1998 - 83% at 2 years of age | 0.7% increase |
| | *Measles immunization Coverage* | Proportion of one year old children immunized against measles. | 1995 - 91.4% (at 2 yrs of age - doses received on or after 1st birthday) | 1996 93.3% | 1998 - 93.6% at 2 years of age | 2.2% increase |
| | *MMR* | | 1993 - 95% (at 2 years of age - doses received on or | 1997 - 94% | 1998 - 94% (at 2 years of age) | 1% decrease |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | Hunger among Canadian Families | Percentage of Canadian families who went without food at least once in one year because of a lack of money or food | - | 1994 - 1.2% or 57,000 families | - | |
| | Children in families using food banks | Percentage of children living in families using food banks, among total food bank users | - | - | 2000 - approx. 40% | |
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| | *Under five deaths from* | Annual number of under-five deaths | - | - | - | |

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| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | | | after 1st birthday) | | | |
| | *Polio immunization Coverage* | Proportion of one year old children immunized against Poliomyelitis. | 1994 - 90% | 1996 - 90%<br>1997 - 86% | 1998 - 90% (at 2 years of age) | No change |
| | *Hib Coverage* | | 1995 - 54.6% | 1996 - 69% | 1998 - 75% (at 2 years of age) | 20.4% increase |
| | *Tuberculosis immunization coverage* | Proportion of one year old children immunized against Tuberculosis. | N/A | N/A | N/A | |
| | *Children protected against neonatal tetanus.* | Proportion of one year old children protected against neonatal tetanus through immunization of their mother. | N/A | N/A | N/A | |
| 23 | a)Reduction by 50 per cent in the deaths due to diarrhoea in children under the age of five years; and<br>b)25 per cent reduction in the diarrhoea incidence rate. | | | | | |
| | *Under five deaths from diarrhoea* | Annual number of under-five deaths due to diarrhoea | N/A | N/A | N/A | |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | *Diarrhoea cases* | Average annual number of episodes of diarrhoea per child under five years of age. | N/A | N/A | N/A | |
| | *ORT Use* | Proportion of under-fives who fall below minus 2 and below minus 3 standard deviations from median height for age of NCHS/WHO reference population. | N/A | N/A | N/A | |
| | *Home Management of Diarrhoea* | Proportion of under-fives who fall below minus 2 and below minus 3 standard deviations from median weight for height of NCHS/WHO reference population. | N/A | N/A | N/A | |
| 24 | Reduction by one third in the deaths due to acute respiratory infections in children under five years. | | | | | |

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|---|---|---|---|---|---|---|
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| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | *Diarrhoea cases* | Average annual number of episodes of diarrhoea per child under five years of age. | N/A | N/A | N/A | |
| | *ORT Use* | Proportion of under-fives who fall below minus 2 and below minus 3 standard deviations from median height for age of NCHS/WHO reference population. | N/A | N/A | N/A | |
| | *Home Management of Diarrhoea* | Proportion of under-fives who fall below minus 2 and below minus 3 standard deviations from median weight for height of NCHS/WHO reference population. | N/A | N/A | N/A | |
| 24 | Reduction by one third in the deaths due to acute respiratory infections in children under five years. | | | | | |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | *Under-five deaths from acute respiratory infections* | Annual number of under-five deaths due to acute respiratory infections (ARI) | - | - | - | |
| | *Care seeking for acute respiratory infections.* | Proportion of children 0-59 months of ages who had ARI in the last two weeks and were taken to an appropriate health provider. | - | - | - | |
| | *Alternate indicator(s):* *Asthma Prevalence* | Asthma prevalence among children aged 0-19 | 1990-8% | 1994-11.2% | 1996/97-12.2%<br><br>0-14-Boys: 13.3%<br>Girls: 9.5%<br><br>15-19-Girls: 14.9% | |

| | **Goal** | **Description** | **1990** | **1996** | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | | | | | Boys: 13.2% | |
| | *Asthma mortality* | Mortality rate for children aged 0-14 with asthma | 1978/79 - 16 | 1983/84 - 13 | 1994/95 - 9 | |
| 25 | Elimination of guinea-worm (dracunculiasis) by the year 2000 | | | | | |
| | Dracunculiasis cases | Annual number of cases of dracunculiasis (guinea worm) in the total population | N/A | N/A | N/A | |
| 26 | Expansion of early childhood development activities, including appropriate low-cost family and community interventions | | | | | |
| | *Preschool development* | Proportion of children aged 36-59 months who are attending some form of organized early childhood education program | - | - | - | |
| | *Alternate Indicators:* | Approx. Number of Canadian children aged 2 to 3 attending some form of early childhood care and education program | - | 1994/95 - 192,000 (39%) | - | |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | *Under-five deaths from acute respiratory infections* | Annual number of under-five deaths due to acute respiratory infections (ARI) | - | - | - | |
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| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | | Educational Program attendance by 4 & 5 year old Canadian Children | | | | |
| | | (a) Kindergarten | - | 1996/97 - 513,000 (64%) | - | |
| | | (b) Early childcare and educational program | - | 198,000 (25%) | - | |
| | | (c) At home with mother | - | 85,000 (11%) | - | |
| 27 | Increased acquisition by individuals and families to the acquisition of knowledge, skills and values required for better living, made available through all educational channels, including, the mass media, other traditional and modern means of communication and social action, with effectiveness measured in terms of the modification of behavioural patterns. | | | | | |
| | *Alternate indicator:* Enhance Access to Information | Connect all Canadian public schools and public libraries to the Internet by March 31, 1999. | - | - | 100% achievement through SchoolNet. | |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | **Additional indicators for monitoring children's rights** | | | | | |
| 28 | Birth Registration | | | | | |
| | | Proportion of children 0-59 months whose births are reported registered | N/A | N/A | N/A | |
| 29 | Children's living arrangements | | | | | |
| | | Proportion of children 0-14 years of age in households not living with biological parent | - | - | - | |
| | | Proportion of children 0-11 years of age in households not living with biological parent | - | 1994-1.2% | - | |
| 30 | Orphans in households | | | | | |
| | | Proportion of children 0-14 years of age who are orphans living in households; proportion of same group who are living in institutions | 1991 - 0.02% under 15, living in orphanages and children's | | | |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
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| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | | | homes | | | |
| 31 | Child Labour | | | | | |
| | | Proportion of children 5-14 years of age who are currently working (paid or unpaid; inside or outside the home) | N/A | N/A | N/A | |
| | *Alternate indicator:* | Proportion of youth (aged 15-19 years) participation in the labour force | 1990- Males: 59% Females: 56% | 1994- Males: 50.5% Females: 48.1% | 1998- Males: 48.3% Females: 47.9% | |
| | **Additional indicators for monitoring HIV/AIDS** | | | | | |
| 32 | Indicators for monitoring HIV/AIDS | | | | | |
| | *Knowledge of preventing HIV/AIDS* | Proportion of women who correctly state the three main ways of avoiding HIV infection. | - | - | - | |
| | *Knowledge of misconceptions of* | Proportion of women who correctly identify three misconceptions about | - | - | - | |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | *HIV/AIDS* | HIV/AIDS. | | | | |
| | *Knowledge of mother to child transmission of HIV* | Proportion of women who correctly identify means of transmission of HIV from mother to child. | - | - | - | |
| | *Attitude to people with HIV/AIDS* | Proportion of women expressing a discriminatory attitude towards people with HIV/AIDS | - | - | - | |
| | *Women who know where to be tested for HIV* | Proportion of women who know where to get an HIV test | - | - | - | |
| | *Women who have been tested for HIV* | Proportion of women who have been tested for HIV | - | - | - | |
| | *Attitude toward condom use* | Proportion of women who state that it is acceptable for women in their area to ask a man to use a condom | - | - | - | |
| | *Adolescent sexual* | Median age of girls/women at first | 1993 - | 1996 - | - | 3% |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
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| 31 | Child Labour | | | | | |
| | | Proportion of children 5-14 years of age who are currently working (paid or unpaid; inside or outside the home) | N/A | N/A | N/A | |
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|---|---|---|---|---|---|---|
| | *HIV/AIDS* | HIV/AIDS. | | | | |
| | *Knowledge of mother to child transmission of HIV* | Proportion of women who correctly identify means of transmission of HIV from mother to child. | - | - | - | |
| | *Attitude to people with HIV/AIDS* | Proportion of women expressing a discriminatory attitude towards people with HIV/AIDS | - | - | - | |
| | *Women who know where to be tested for HIV* | Proportion of women who know where to get an HIV test | - | - | - | |
| | *Women who have been tested for HIV* | Proportion of women who have been tested for HIV | - | - | - | |
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| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | *behaviour* | pregnancy. | 25-29 34.9%<br>30-34 28.9% | 25-29 31.9%<br>30-34 30.3% | | decrease 1.4%<br>increase |
| | *Alternate Indicators* | Proportion of AIDS cases among adult women. | <1990 - 5.6% AIDS cases among adult women. | 1994 - 7.7% AIDS cases among adult women | 1999 - 16.3% AIDS cases among adult women. | 11.8% increase |
| | | Total number of female AIDS cases | 1990 - 69 AIDS cases | 1994 - 141 AIDS cases | 1999 - 42 AIDS Cases | 40% decrease |
| | *HIV Prevalence* | Proportion of positive HIV tests by gender | <1995 - Females 9.6% Males 90.4% | 1995 - Females 18.5% Males 81.5% | 1999 - Females 23.9% Males 76.1% | |
| | | Total number of AIDS cases among children aged 0 to 14 years | 1990 - Females 5 | 1995 - Females 12 | 1999 - Females 1 | |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | | | Males 6 | Males 15 | Males 1 | |

| | Goal | Description | 1990 | 1996 | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | *behaviour* | pregnancy. | 25-29 34.9%<br>30-34 28.9% | 25-29 31.9%<br>30-34 30.3% | | decrease 1.4%<br>increase |
| | *Alternate Indicators* | | | | | |
| | | Proportion of AIDS cases among adult women. | <1990 - 5.6% AIDS cases among adult women. | 1994 - 7.7% AIDS cases among adult women | 1999 - 16.3% AIDS cases among adult women. | 11.8% increase |
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| | **Goal** | **Description** | **1990** | **1996** | 2000 | Results 1990-2000 |
|---|---|---|---|---|---|---|
| | | | Males 6 | Males 15 | Males 1 | |

## Appendix 2

### I. Shared Jurisdictional Responsibility in Canada

a) Federal-Provincial Responsibilities

Generally speaking, the Canadian political system embodies the four following characteristics: it is a constitutional monarchy; it is a federal system; it is a parliamentary system on the British model; and it is a representative democracy. In Canada=s federal system, the Constitution confers legislative and executive powers on two levels of government, which are each sovereign in their respective spheres. There is a central government for all Canada, and a government for each province and territory. The *Constitution Act, 1867*, defines the federal and provincial responsibilities. The present division of powers results, in part, from the application and the interpretation of the wording of the Constitution by the courts.

Federal Parliament has the power to levy taxes by any mode of taxation, and the federal government has the authority to allocate its financial resources, as it deems appropriate. The federal government can, for example, make grants to individuals with a view to promoting research and development. The federal government also uses its spending power to initiate shared-cost programs in areas of health, education and welfare services in the provinces. Finally, the federal government initiated a program of equalization payments to provinces whose revenues were below the national average. These unconditional payments were designed to help these provinces provide an appropriate range of public services.

The federal government controls monetary policy. This includes responsibility for issuing currency and for the national economic stability to manage unemployment and inflation, control of the banking system and regulation of interest rates. Monetary policy includes responsibility for the value of Canadian currency on international markets. The task of setting and applying monetary policy is assigned by the federal government to the central bank, the Bank of Canada.

Parliament has jurisdiction over international and interprovincial trade. It also has exclusive jurisdiction over customs duties. Standardization of products intended for international or interprovincial trade and export quotas are within Parliament's jurisdiction. General foreign investment policy is also under its authority.

The federal government has jurisdiction over defence and relations with other states and has authority to enter into international treaties. However, either or both the federal Parliament and the provincial legislatures may have jurisdiction to implement treaties, depending on whether the subject matter of the treaty comes under federal or provincial responsibility as defined in the Constitution. This system operates through federal-provincial cooperation: before entering into a treaty relating to fields that do not fall solely within the jurisdiction of Parliament, the federal government ensures that it has the consent of the provinces to cooperate in implementing the treaty (see below).

Other matters within Parliament's jurisdiction include navigation and shipping, fisheries, bankruptcy, Indians and lands reserved for Indians, naturalization, citizenship, criminal law, patents and copyrights. The postal service and employment insurance are within federal jurisdiction.

Any matter that is not within the jurisdiction of the provincial legislatures is automatically assigned to the federal Parliament. In interpreting federal and provincial powers, the courts have held that certain new subject matters, such as air transportation, are under the jurisdiction of the federal Parliament by virtue of its general power to make laws for the peace, order and good government of Canada in relation to all matters not assigned exclusively to the legislatures of the provinces. The courts view the general federal power as including a power to legislate in emergencies such as war.

The provinces have numerous legislative powers, including authority over property and civil rights (primarily proprietary, contractual or tortious rights), natural resources, works and undertakings of a local nature, and, generally, all matters of a merely local and private nature. The courts have interpreted the provincial powers, especially "property and civil rights", as covering a very wide field. The Constitution does not mention labour relations specifically, but the courts have placed that subject under provincial jurisdiction, except for certain industries that are under federal jurisdiction for other purposes, such as navigation and shipping industries.

Services and institutions that fall within provincial jurisdiction include health and social services, municipal institutions and land development, the administration of justice, the development and organization of provincial courts of both civil and criminal jurisdiction, and education.

The provincial legislatures have the power to levy direct taxes (e.g. income taxes) within the province, to raise revenue for provincial purposes. In addition, the provinces are given the power to levy direct and indirect taxes in relation to natural resources. The provinces also have the power to issue licences to raise revenue for provincial or municipal purposes.

The Constitution assigns concurrent jurisdiction over agriculture and immigration to the provincial legislatures and Parliament. Federal legislation will prevail in the event that it is inconsistent with provincial legislation. The provinces also share jurisdiction with the federal government in relation to old age pensions.

The powers of the provincial legislatures are limited to those given to them by the Constitution. This means that no provincial legislature can take over powers that belong exclusively to Parliament. Similarly, Parliament cannot take over powers that belong exclusively to the provinces. Although Parliament and the provincial legislatures cannot interdelegate legislative powers, Parliament can delegate powers to provincial agencies and a provincial legislature can likewise delegate powers to a federal agency. Parliament and a provincial legislature can adopt as its own legislation of the other level of government, as long as they both act in their area of jurisdiction.

b) Aboriginal Peoples of Canada: Definitions

*Aboriginal Peoples of Canada:* Aboriginal Peoples of Canada are the descendants of the original inhabitants of North America. The Canadian Constitution recognizes three groups of Aboriginal people - Indians, Métis and Inuit. These are three separate peoples with unique heritages, languages, cultural practices and spiritual beliefs.

*Indian:* Indian is a term that describes all the Aboriginal people in Canada who are not Inuit or Métis. Indian peoples are one of three groups of people recognized as Aboriginal in the Constitution Act, 1982. The act specifies that Aboriginal people in Canada consist of Indians, Inuit and Métis. In addition, there are three legal definitions that apply to Indians in Canada: Status Indians, Non-Status Indians and Treaty Indians. Many Aboriginal people today find the term "Indian" outdated and offensive. They prefer the term "First Nation."

*Registered or Status Indian:* A Status or Registered Indian is an Indian person who is registered under the Indian Act. The act sets out the requirements for determining who is a Status Indian.

*Non-Status Indian:* A Non-Status Indian is an Indian person who is not registered as an Indian under the Indian Act. This may be because his or her ancestors were never registered, or because he or she lost Indian status under former provisions of the Indian Act.

*Treaty Indian:* A Treaty Indian is a Status Indian who belongs to a First Nation that signed a treaty with the Crown.

*Reserve:* A reserve is land set aside by the federal government for the use and occupancy of an Indian group or band.

*First Nation:* This is a term that came into common usage in the 1970s to replace the word "Indian," which many people found offensive. Although the term First Nation is widely used, no legal definition of it exists. Among its uses, the term "First Nations peoples" refers to the Indian people in Canada, both Status and Non-Status. Many Indian people have also adopted the term "First Nation" to replace the word "band" in the name of their community.

The federal government has responsibility for delivering services and programs, comparable to those available more broadly across the country, to First Nations living on reserve and to the Inuit peoples. It also plays a leadership role with respect to off-reserve Aboriginal populations, including Aboriginal children. While significant progress has been made in recent years, Aboriginal children continue to fall far behind the Canadian average on most indicators of health and well-being.

c) Territories
The Yukon, Northwest Territories and Nunavut have legislative, executive and judicial powers that are becoming similar to those exercised by the provinces. The constitutions of the three territories are set out in specific Acts, which, reflecting their special status with Confederation, are federal statutes.

d) Municipalities
Municipal governments (cities, towns, villages and metropolitan regions) are created by the provincial legislatures and have such powers as the legislatures see fit to give them. Mayors and municipal councillors are elected in accordance with the requirements laid down by the legislature. Throughout Canada, there are some 5,000 municipal governments. These governments provide Canadians with such services as water supply, sewage and garbage disposal, roads, sidewalks, street lighting, building codes, parks, playgrounds, libraries and so on. School boards elected according to provincial legislation generally administer schools.

**II. International Instruments and the Federal System**

According to Canada's Constitution, powers are divided among federal, provincial and territorial governments, each of which has the power to legislate upon matters that directly affect various aspects of human rights. This division of powers must be taken into account in the ratification and implementation by Canada of international human rights treaties and in reporting on them. The federal government has the exclusive power to ratify international treaties. However, it does not have the power to legislate in matters of provincial jurisdiction in order to fulfill any international obligations that it may have undertaken. In other words, the federal government cannot use the signing of an international convention as a way of impinging on provincial or territorial powers.

Provinces and territories must be willing partners in the implementation of treaties and conventions. Consequently, full participation in international instruments requires that the federal, provincial and territorial governments work closely together at all stages, from the preparatory work preceding ratification, and on to subsequent implementation and periodic reporting.

To help ensure this cooperation, a Federal-Provincial Conference of Ministers Responsible established an intergovernmental mechanism in 1975 for Human Rights (at the federal level, this Minister was the former Secretary of State, now the Minister of Canadian Heritage). The mandate of this continuing Committee of Officials on Human Rights is to maintain consultation and collaboration among governments with respect to the ratification, implementation and reporting on international human rights instruments.

**III. The Judicial Branch**

Canada upholds a bi-juridical legal system that includes a common and civil law system. The laws that deal with private matters between individuals, such as property ownership, family responsibilities and business transactions, vary from province to province. This area of law is based on common law in nine of Canada's 10 provinces. Common law is a system based on judgments made by courts, which become "precedents" that establish the underlying principles of the law. The law in Quebec, however, is based on a written code (the Code civil), which contains general principles and rules for different types of situations. When a case is considered under civil law, a judge looks first to this written code for guidance and then to the precedents set by earlier decisions.

The Canadian judicial system consists of superior courts and lower courts. The first, as courts of original general jurisdiction, have inherent jurisdiction, which makes it possible for them to hear anything that is not within the limited exclusive jurisdiction of a lower court, and to have superintending and reforming power over the lower courts. On the other hand, the lower courts have only the jurisdiction expressly conferred on them by the competent legislative body. Lower and superior courts have jurisdiction regarding the constitutionality of legislation.

Each province has a superior trial court and a court of appeal. These superior courts are constituted by the provincial legislature, but their members are appointed and paid by the federal government. As well, in each province, there are lower courts-provincial or municipal courts - which the legislatures create and whose members are appointed by provincial governments.

The Supreme Court of Canada is the general appellate court of last resort for all of Canada. As the final interpreter of the Constitution, its decisions may influence the direction of federalism, in terms of the division of powers, or may question the constitutionality of government policies, in terms of human rights and fundamental freedoms.

Parliament has also established the Federal Court, which has particular jurisdiction to hear cases involving the federal government and to review the decisions of federal boards, commissions and tribunals. In addition, both federal and provincial legislation assign functions to administrative tribunals that are essentially judicial. These specialized tribunals have specific responsibilities such as immigration, international trade, competition, radio-television and telecommunications, securities and residential tenancies, etc.

Although powers with respect to the judiciary are distributed between the federal government and the provinces, integration is a primary characteristic of the Canadian judicial system. The provincial courts can determine matters of both federal and provincial law, and there is no distinction between constitutional, administrative, criminal and civil jurisdiction. The integration is further reflected in the fact that all cases, whether arising under federal or provincial law, are capable of ending up in the same final appeal court, the Supreme Court of Canada.

The Canadian courts operate independently of the federal and provincial legislative bodies and governments. The Constitution Act, 1867 adopted the judicial independence features that had been introduced in Canada in the earlier decades. The Canadian Charter of Rights and Freedoms also protects judicial independence.

# Appendix 3

**Provincial and Territorial Supplementary Reports to Canada's National Report: United Nations General Assembly Special Session for Children (WSC+10)**

**Note:** The federal government invited the participation of Canada's provincial and territorial governments in the end of decade review process following the World Summit for Children. Their participation in the review of Canada's National Report was coordinated through the Federal-Provincial-TerritorialCommittee of Human Rights Officials. In addition to their participation in this review, each province and territory may also choose to prepare and submit a report with respect to their jurisdiction. In some cases, provinces and territories have provided supplemental information that has been included in the body of this report. The contribution by one province, Ontario, is presented in the following appendix for ease of reference.

## Ontario's Progress on Child Health

Ontario's Public Health Branch overseas a number of programs that support child health and well-being. Local Boards of Health across the province deliver the Public Health Mandatory Health Programs and Services. Public Health's population-based approach to health promotion and primary prevention is complemented by programs and services that aim to identify and support populations at increased risk for poor health outcomes. The Healthy Babies Healthy Children Program, Preschool Speech and Language initiative, and newly introduced Infant Hearing Screening and Communication Development Program are examples of more targeted supports for child health that Public Health is involved in.

Provincial Public Health objectives and requirements range from the promotion of preconception health and healthy pregnancies, through early growth, development and readiness to learn, to the well being of youth. Such a comprehensive approach includes initiatives to enhance the capacity of parents, families, caregivers and communities to care for and support children and youth.

In addition to the Reproductive and Child Health programs, a number of Public Health Programs address a variety of determinants relevant to child health. These include immunization against infectious disease, the protection of healthy natural and physical environments, the prevention of injuries and substance abuse, the promotion of sexual health and healthy lifestyle choices, and the creation of safe and supportive social environments. Ontario has been a major contributor to improvements in children=s well being. Significant achievements by Ontario include:

- The investment in the Learning Opportunities Grant to assist children at-risk;
- The investment of $70 million in improving reading skills, Junior Kindergarten to Grade 3;
- The investments the Ontario Ministry of Training, Colleges and Universities has made to colleges and universities to improve access to postsecondary education for all qualified applicants;
- The investment in Safe Schools and Code of Conduct programs to make schools a safe learning environment for children;
- The investment in setting standards for exceptionalities so that children with disabilities receive a quality education;
- The investment in Transition to Work programs for youth to enter the work force.

| Goal | Description |
|---|---|
| 1 | **Infant mortality** Ontario=s rate has dropped by 12.8% from 1990 (6.27 per 1,000 live births to 5.47 in 1997). The 1997 Ontario infant mortality rate is slightly lower than the national rate of 5.53. However, a greater improvement was seen nationally from the 1990 infant rate of 6.84, a reduction of 19.2%. |
| 2 | **Maternal mortality** The rate in Ontario has increased from 4.89 in 1995 to 19.55 in 1997. Over the same years, the rate in Canada went from 4.5 in 1995 to 10.9 in 1997. As the actual numbers of maternal deaths in Ontario, and in Canada as a whole, are small, fluctuations from year to year appear as very large changes in the rates, therefore this indicator should be assessed with some caution. |
| 9 & 32 | **HIV/AIDS** The proportion of positive HIV tests by gender in Ontario were as follows: for 1990, 91.7% male and 8.3% female; for 1996, 81.6% male and 18.4% female; and for 1999 79.9% male and 20.1% female. There have not been any studies on knowledge, attitude or behaviour related to HIV done in Ontario. Ontario AIDS cases were reported as follows. For 1990 there were 619 male cases and 34 female cases (5.25%); for 1996 there were 577 male cases and 44 female cases (7.1%); and for 1999 there were 101 male cases and 18 female cases (15.1%). In 1999 there was a 42% decrease in women reported with AIDS compared to 1998. The total number of AIDS cases in children 0 to 14 years in the period 1981 to 1999 was 68. In 1999 there were 2 male and 2 female newly reported cases. |
| 10 | **Total fertility rate**: Ontario=s 1997 rate of 1.53 compares to a national rate of 1.55. While the Ontario rate declined 8.4%, from a rate of 1.67 in 1990, the rate in Canada dropped 9.3% from 1.71 in 1990. |
| 12 | **Low Birth Weight**: Ontario=s low birth weight (LBW) rate for 1997 is slightly higher than the national rate (5.86% in Ontario compared to 5.75% for Canada). Since 1990, Ontario=s LBW rate has increased by 8.9% (from 5.38%), while Canada=s rate has increase by 5.9% (from 5.43% in 1990). |
| 16 | **Breastfeeding**: In Ontario, 81.2% of mothers have breastfed, and 59.2% of mothers' breastfed for at least three months (Statistics Canada, National Longitudinal Survey of Children and Youth 1996/97 as cited in the Canadian Perinatal Health Report, 2000). |

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|---|---|
| | This compares favourably with the national rates of 76.7% mothers ever having breastfed and 53.6% who breastfed for at least three months. |
| 18 | **Use of food banks:** children living in families who used a food bank : Of all food bank recipients in Ontario in 1998, 42.5% were children (data from the Canadian Association of Food Banks, 1999, cited by The Canadian Institute of Child Health, 2000). |
| 20 & 22 | **Immunization against Diphtheria, Pertussis, Tetanus (DPT) and Polio** among 2 year olds : Immunization coverage data in Ontario is collected for the school-age population, which is presented as an alternate indicator for 2 year olds. For a 2-year old to be up-to-date with their DPT and Polio vaccinations they should have received 4 doses of vaccine before their 2nd birthday. Ontario results of a 1997 Vaccine Coverage Survey show 85.1% of school-age children up to date for Diphtheria, 84.2% up-to-date for Pertussis, 84.8% up-to-date for Tetanus, and 80.2% were up-to-date for Polio. |
| 21 & 22 | **Coverage for Measles** at 2 years old : Again, immunization coverage data for the Ontario school-age population is presented as an alternate indicator for 2 year olds. For a 2-year old to be up-to-date for Measles, one dose of Measles vaccine is required. Ontario results of a 1997 Vaccine Coverage Survey show 95.0% coverage for Measles of school-age children. |
| 23 | **Age specific fertility rate**: The age specific fertility rate per 1,000 women aged 15-19 in Ontario was 17.24 in 1997, compared to 20.19 nationally. This represents a decline of 20.0% in Ontario from the 1990 rate of 21.55, and a 20.7% decline nationally from the 1990 rate for Canada of 25.46. |
| **Alternate Indicators:** | |
| | **Substance Use - Smoking**: (Data from the 1999 Ontario Student Drug Use Survey carried out by the Centre for Addictions and Mental Health for Ontario youth in grades 7 through 13). An estimate of 22.6% of students smoked daily. The rate of having smoked more than one cigarette during the past 12 months was 29.2% (29.8% of males and 28.6% of females). Although rates of smoking have remained stable since 1995, the 1999 rate of smoking, and of average cigarettes consumed daily for the late 1990s were greater than earlier years. These numbers are somewhat higher than the results found in the OHS 1996/97 survey of teenagers 12 to 19 years. This survey estimated that 13% of teens in this age group smoke on a regular basis, roughly the same proportion as reported smoking in 1990. In 1996, slightly more males (14%) than females (11%) reported smoking on a daily basis. |

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|---|---|
| | **Substance Use B Alcohol**: (Data from the 1999 Ontario Student Drug Use Survey carried out by the Centre for Addictions and Mental Health for Ontario youth in grades 7 through 13). In 1999, 19.7% of drinkers drank weekly, a significant increase from 17.1% in 1997 and 14.4% in 1993. In 1999, 67.5% of all students reported drinking during the previous 12 months. Past year drinking was higher for males than females (70.7% vas 64.2%), and varied by grade (increasing from 39.7% of 7th graders to 84.6% of 12th graders). The percentage of drinkers increased significantly from 1997 to 1999 among the total sample (59.6% to 65.7%). Increases in past year drinking were especially notable since 1993. |
| | **Children living in low-income families**: From 1990-1996 the largest increases in the number and proportion of low income Canadians occurred in Ontario (Statistics Canada, as cited in The Federal, Provincial and Territorial Advisory Committee on Population Health, 1999). The percentage of low-income families in Ontario increased from 10.9% in 1991 (based on 1990 income levels) to 14.8% in 1996 (based on 1995 income levels). The proportion of Ontario children under 18 living in poor families rose from 15% in 1990 to 20% in 1996. Comparing children 0-9 years old with those 10-17 years old, the trend revealed higher rates of low income for young children (Statistics Canada data, as cited in the Report on the Health Status of the Residents of Ontario, 2000). |
| | **Childhood prevalence of asthma**: Ontario data on asthma rates for children is not available. Asthma hospital separation rates in Ontario for children aged 0-14 years increased from 252.9 (per 100,000) in 1974/75 to 670.9 in 1987/88, and then decreased to 463.5 by 19994/95. |
| | While data on the proportion of **children regularly exposed to tobacco smoke** in the home was not available, 31% of Ontarians 12 years and older report living with someone who regularly smokes in the home (NPHS, 1996/97). This compares to 33% of Canadian children under 12 who are regularly exposed to tobacco smoke in their home. |